PART I

Section I

Consumer Eligibility, Service Definitions, and Service Guidelines

For

Mental Health and Addictive Disease Services

PROVIDER MANUAL
FOR
COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS
FOR
THE DIVISION OF MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES

JULY 2006

CONSUMER ELIGIBILITY- CHILD AND ADOLESCENT CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. SERVICE ACCESS

Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted.

A brief assessment should be initiated by all community-based service providers on all consumers who present for services or who are referred by the Access Crisis Line/Single Point of Entry for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of an individual's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further diagnostic assessment and admission to at least Brief Stabilization services.

1. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.
2. If the individual does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the individual may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive diagnostic assessment (possibly resulting in the individual moving directly into Ongoing Services). The brief assessments, comprehensive diagnostic assessment and the Core Customer determination are part of the Diagnostic Assessment service and may be billed as such, <u>unless</u> the individual is determined not to be a Core Customer.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are four variables for consideration to determine whether a youth qualifies as a “core customer” for child and adolescent mental health and addictive disease services.

1. **Age:** An individual must be under the age of 18 years old. Individuals aged 18-21 years (children still in high school, in DJJ or DFCS custody or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services.
2. **Diagnostic Evaluation:** The state MHDDAD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual’s type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnosis.

3. **Functional/Risk Assessment:** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes child and family resource utilization and the child's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. **Financial Eligibility:** For state funded supports, the individual must have no other means of paying for the services needed. If there are no other means to pay for the authorized services then the consumer will pay based on his/her ability to pay in accordance with the Division's Policy on Consumer Fee Collections and Sliding Fee Scale.

C. PRIORITY FOR SERVICES

The following individuals are priority for services. These individuals once it has been determined they meet core customer must be seen within 2 hours of contact if in crisis, within 24 hours for emergent problems and within 5 days from application or referral for services for routine needs.

1. The first priority group for services is:
   - Individuals at risk of out-of home placements;
   - Individuals who are in out of home placements; and,
   - Individuals currently in a state operated psychiatric facility or a community based crisis residential service including a crisis stabilization program.

2. The second priority group for services is:
   - Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
   - Individuals with a history of one or more crisis stabilization program admissions within the past 3 years;
   - Individuals with a history of enrollment on an Intensive Family Intervention team within the past 3 years;
   - Individuals with court orders to receive services;
   - Individuals under the correctional community supervision with mental illness or substance use disorder or dependence;
   - Individuals released from secure custody (county/city jails, state RYDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
   - Pregnant women;
   - Individuals who are homeless; or,
   - IV drug Users.

D. EARLY INTERVENTION AND STABILIZATION- CHILD AND ADOLESCENT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Early Intervention and Stabilization services is 90 days or less. Early Intervention and Stabilization services are limited to the provision of the following services and unit allowances:

1. Diagnosis Assessment and Individual Recovery Planning: up to 8 units
2. Crisis Intervention: no limit prior to Core Customer Brief Services Evaluation, and up to 8 units post Core Customer Brief Services Evaluation.
3. Pharmacy Services (no limit).
4. 12 units total of one or more of the following:
    a. Physician Assessment and Care; and/or
    b. Nursing Assessment and Care; and/or
    c. Medication Administration.
5. 24 units total of one or more of the following:
    a. Individual Counseling/Training; and/or
    b. Family Counseling/Training; and/or
    c. Group Counseling/Training.

NOTE: The concept of "visits" is no longer applicable after July 1, 2006.

Early Intervention and Stabilization services **must take place within a ninety (90) day timeframe**. Individuals must be registered/authorized for Early Intervention and Stabilization services (complete Part 1- "Registration" of the Multipurpose Information Consumer Profile) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the Part I.

While those registered in Early Intervention and Stabilization services only will not need a prior authorization for services (MICP Part 2- "Prior Authorization,"), a service plan must still be completed to guide the provision of services in accordance with the Division's standards and the provider's accrediting entity, and the plan must be maintained in the consumer's record.

Early Intervention: Indicates interventions taking place after a problem (e.g. an emotional disturbance and/or substance related disorder) is already suspected or identified, but that occur early enough to potentially avoid escalation of the problem into a crisis situation or into a chronic/significantly disabling disorder.

In order for an individual to qualify for Child And Adolescent Mental Health And Addictive Diseases Early Intervention services, certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.

2. **Functional-** The individual child/adolescent's level of functioning must meet **at least one** of the following criteria:

    a. is affected by an emotional disturbance or substance related disorder;
    b. has shown early indications of behaviors that could be disruptive to the community and the family/support system if behaviors intensified,
    c. has shown early indications behaviors/functional problems that could cause risk of removal from the home if problems intensified;
    d. has shown early indications of poor school performance (poor grades, disruptive behavior, lack of motivation, suspension);
    e. has shown early indications of delinquent behaviors that could result in legal system involvement; and/or
    f. has shown early indications of behavioral/functional problems that could result in multiple agency involvement if problems intensified.

Stabilization: Indicates interventions taking place after a problem has been identified (e.g. an emotional disturbance and/or substance related disorder) and has either developed into a crisis situation or become disabling enough to warrant at least short-term stabilization interventions.

In order for an individual to qualify for **Child and Adolescent <u>MENTAL HEALTH AND ADDICTIVE DISEASES STABILIZATION</u> services,** certain diagnostic **<u>and</u>** functional criteria must be met, including the following:

1. **Diagnostic**- The individual child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.

2. **Functional -** The individual child/adolescent's level of functioning must meet **at least one** of the following criteria:

    a. is significantly affected by a serious emotional disturbance or substance related disorder;
    b. results in behaviors that demonstrate a risk of harm to self, others, or property;
    c. causes a risk of removal from the home;
    d. results in school problems such as poor grades, school failure, disruptive behavior, lack of motivation, drop out, suspension or expulsion;
    e. results in legal system involvement;
    f. indicates the need for detoxification services; and/or
    g. is significantly disruptive to the community or the family/support system.

E. ONGOING SUPPORT AND TREATMENT- CHILD AND ADOLESCENT MENTAL HEALTH

Ongoing Support and Treatment: Indicates interventions taking place after an emotional disturbance of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the child and family in order to improve the child's level of functioning and resilience. The length of Ongoing Support and Treatment services is anticipated to be longer than 90 days (though how much longer varies by utilization guidelines, service needs and bio-psycho-social factors affecting functioning). An individual may either start out in Ongoing services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors.

For an individual/family to qualify for **Child and Adolescent <u>MENTAL HEALTH ONGOING SUPPORT AND TREATMENT</u> services**, certain diagnostic **<u>and</u>** functional criteria must be met, including the following:

1. **Diagnostic-** The individual child/adolescent must have a primary diagnosis of a serious emotional disturbance on Axis I, (***for example***: major depression, an anxiety disorder, or other serious emotional disturbance). ***This must be a diagnosis, not just a diagnostic impression.*** The disturbance must have persisted for at least one year or be likely to persist for at least one year without treatment, and must require ongoing, longer-term support and treatment services. Without such services, out of home placement or hospitalization is probable.

2. **Functional-** The individual child/adolescent's ability to function has been significantly affected by the serious emotional disturbance to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. Functional impairment must be demonstrated by ***<u>one</u> of the following three indicators***:

    a. A total score of 60 or higher on the 8 subscales of the Child and Adolescent Functional Assessment Scale (CAFAS),

    --OR—

    b. **Either** a score of *20 or higher* (*moderate to severe impairment)* on the "Behavior Toward Others", the "Self-Harmful Behavior" or the "Thinking" CAFAS subscale, **or** a score of *30 (severe impairment)* on the "Moods/Emotions" CAFAS subscale,

    --OR--

    c. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

F. ONGOING SUPPORT AND RECOVERY- CHILD AND ADOLESCENT ADDICTIVE DISEASES

Ongoing Support and Recovery: Indicates interventions taking place after a substance related disorder has been identified and has become disabling enough to warrant ongoing service provision to assist in stabilizing/supporting the child and family, and to facilitate the child's recovery. The length of service is anticipated to be longer than 90 days (though how much longer varies by utilization guidelines, service needs and bio-psycho-social factors affecting recovery). An individual may either start out in Ongoing services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors.

For a person to qualify for **Child and Adolescent <u>ADDICTIVE DISEASES ONGOING SUPPORT AND RECOVERY</u> services**, certain diagnostic **<u>and</u>** functional criteria must be met, including the following:

1. **Diagnostic-** The child/adolescent must have a primary diagnosis on Axis I of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin (Caffeine and nicotine are excluded). ***This must be a diagnosis, not just a diagnostic impression.***

2. **Functional-** The child/adolescent's ability to function has been significantly affected by the substance related disorder to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. This functional difficulty must be demonstrated by ***<u>one</u> of the following two indicators***:

   a. A score of 20 or higher (moderate to severe impairment) on the 'Substance Abuse" subscale of the Child and Adolescent Functional Assessment Scale (CAFAS).

   --OR--

   b. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

G. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. **Child and Adolescent Mental Health:**
   a. Axis I disorders classified in the most recent version of the DSM.
   b. By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor *or* its consequences.
   c. **Exclusions:** The following disorders are ***excluded*** unless co-occurring with a qualifying primary Axis I emotional disturbance or substance related disorder that is the focus of treatment:
      1. Tic disorders;
      2. Mental Retardation;
      3. Learning Disorders;
      4. Motor Skills Disorders;
      5. Communication Disorders;
      6. Organic Mental Disorders;
      7. Pervasive Developmental Disorders; and,
      8. V Codes

2. **Child and Adolescent Addictive Diseases:**
   a. Substance Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal as classified in the most recent version of the DSM.
   b. The severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
   c. Exclusions: The following disorders are ***excluded:***
      1. Caffeine-Induced Disorders;
      2. Nicotine-Related Disorders; and,
      3. Substance Intoxication- only excluded for Ongoing Services.

NOTE*: The presence of co-occurring emotional disturbances, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation.*

Consumers diagnosed with the excluded Axis I disorders listed above and/or with Axis II disorders may receive services ***ONLY*** *when these disorders co-occur with a qualifying primary Axis I emotional disturbance or substance related disorder. The qualifying Axis I emotional disturbance or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the consumer must meet the functional criteria listed above.*

H. CONTINUED REVIEW OF ELIGIBILITY

Eligibility will be reviewed as consumers' MICP service reauthorizations become due.

CONSUMER ELIGIBILITY- ADULT CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. SERVICE ACCESS

Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted.

A brief assessment should be initiated by all community-based service providers on all consumers who present for services or who are referred by the Access Crisis Line/Single Point of Entry for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of an individual's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation and admission to at least Brief Stabilization services.

1. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.
2. If the individual does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the individual may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive diagnostic assessment (possibly resulting in the individual moving directly into Ongoing Services). The brief assessment, comprehensive diagnostic assessment and Core Customer evaluations are part of the Diagnostic Assessment service and may be billed as such, unless the individual is determined not to be a Core Customer.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services.

1. **Age:** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.
2. **Diagnostic Evaluation:** The state MHDDAD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes the individual's resource utilization, role performance,

social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. **Financial Eligibility:** For state funded supports, the individual must have no other means of paying for the services needed. If there are no other means to pay for the authorized services then the consumer will pay based on his/her ability to pay in accordance with the Division's Policy on Consumer Fee Collections and Sliding Fee Scale.

C. PRIORITY FOR SERVICES

The following individuals are the priority for ongoing support services These individuals once it has been determined they meet core customer must be seen within 2 hours of contact if in crisis, within 24 hours for emergent problems and within 5 days from application or referral for services for routine needs.

1. The first priority group for services is individuals currently in a state operated psychiatric facility, state funded/paid inpatient services, a crisis stabilization or crisis residential program.
2. The second priority group for services is:
   - Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
   - Individuals with a history of one or more crisis stabilization program admissions within the past 3 years;
   - Individuals with a history of enrollment on an Assertive Community Treatment team within the past 3 years;
   - Individuals with court orders to receive services;
   - Individuals under the correctional community supervision with mental illness or substance use disorder or dependence;
   - Individuals released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
   - Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
   - Pregnant women;
   - Individuals who are homeless; or,
   - IV drug Users.

D. BRIEF STABILIZATION- ADULT MENTAL HEALTH AND ADDICTIVE DISEASES

Brief Stabilization services are limited to the provision of the following services and unit allowances:

1. Diagnosis Assessment and Individual Recovery Planning: up to 8 units

2. Crisis Intervention: no limit prior to Core Customer Brief Services Evaluation, and up to 8 units post Core Customer Brief Services Evaluation.
3. Pharmacy Services (no limit).
4. 12 units total of one or more of the following:
    a. Physician Assessment and Care; and/or
    b. Nursing Assessment and Care; and/or
    c. Medication Administration.
5. 24 units total of one or more of the following:
    a. Individual Counseling/Training; and/or
    b. Family Counseling/Training; and/or
    c. Group Counseling/Training.

*** NOTE:** The concept of "visits" is no longer applicable after July 1, 2006.

Brief Stabilization services **must take place within a ninety (90) day timeframe**. Individuals must be registered/authorized for Brief Stabilization services (complete Part 1- "Registration" of the Multipurpose Information Consumer Profile) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the Part I.

While those registered in Brief Stabilization services only will not need a prior authorization for services (MICP Part 2- "Prior Authorization,"), a service plan must still be completed to guide the provision of services in accordance with the Division's standards and the provider's accrediting entity, and maintained in the consumer's record.

Brief Stabilization indicates interventions taking place after a problem has been identified (e.g. a psychiatric disturbance/disorder and/or substance related disorder), which has either already developed into a crisis situation or has become disabling enough to warrant at least short-term, low intensity outpatient stabilization interventions.

In order for an individual to qualify for Adult Mental Health And Addictive Diseases Brief Stabilization services**,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The person must have an Axis I diagnosis or diagnostic impression of a mental illness and/or a substance related disorder.
2. **Functional-** Item ***"a"*** **AND** at least item ***"b"*** **OR** ***"c"*** must be present:
    a. The person's level of functioning must be significantly affected by the presenting mental health and/or addictive disease issue; and one or more of the following:
    b. The person displays behaviors that are significantly disruptive to the community, to the individual's family/support system, or to the individual's ability to maintain his or her current employment/schooling, housing or personal health/safety; **and/or**
    c. The person displays behaviors that demonstrate a potential risk of harm to self or others.

E. ONGOING SUPPORT AND RECOVERY- ADULT MENTAL HEALTH

An individual may either begin in Ongoing services or be transitioned from Brief services into Ongoing services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc.

Individuals for whom Ongoing services are desired must first complete Part 1- "Registration" of the MICP (though this does not need to be done again if the individual is currently receiving Brief services) regardless of whether or not the individual ever receives Brief services. The individual must then be qualified for Core Customer Ongoing Support and Recovery services, and a prior authorization must be obtained prior to Ongoing services initiation (i.e. MICP Part 2- "Prior Authorization" must be completed and authorized).

Ongoing Support and Recovery: Indicates interventions taking place after a psychiatric disorder of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the individual in order to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies based on consumer service needs and bio-psycho-social factors affecting functioning and service utilization guidelines. An individual may either start out in the Ongoing services category or be transitioned to this category at any point during or following Brief Stabilization services due to changes in clinical presentation, needs, circumstances or stressors etc.

In order for an individual to qualify for Adult Mental Health Ongoing Support And Recovery Services**,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual must have an Axis I diagnosis (**note:** not just a diagnostic impression) of a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder that requires ongoing and long-term support, treatment and recovery services. The prognosis indicates a long-term, severe disability. Without supports, hospitalization or other institutionalization (e.g. incarceration) is probable.
2. **Functional-** The individual's ability to function has been **significantly affected by the mental disorder** to the degree that there is impairment in activities of daily living with an inability to function independently in the community. This difficulty with activities of daily living and difficulty in functioning independently must be demonstrated **EITHER** by ***both "a" and "b"*** below, **OR** ***by "c" alone.***
   a. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 1 level of care.

   --AND--

   b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or

her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.

--OR--

c. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 2 or above level of care.

F. ONGOING SUPPORT AND RECOVERY- ADULT ADDICTIVE DISEASES

An individual may either begin in Ongoing services or be transitioned from Brief services into Ongoing services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc.

Individuals for whom Ongoing services are desired must first complete Part 1- "Registration" of the MICP (though this does not need to be done again if the individual is currently receiving Brief services), regardless of whether or not the individual ever receives Brief services. The individual must then be qualified for Core Customer Ongoing Support and Recovery services, and a prior authorization must be obtained within 30 days of Ongoing services initiation (i.e. MICP Part 2- "Prior Authorization" must be completed and authorized).

Ongoing Support and Recovery: Indicates interventions taking place after a substance related disorder has been identified, and has become disabling enough to warrant ongoing service provision to help support the individual to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies by service utilization guidelines, support and recovery needs, and by other bio-psycho-social factors affecting functioning.

In order for a person to qualify for **Adult <u>ADDICTIVE DISEASE ONGOING SUPPORT AND RECOVERY</u> services,** certain diagnostic **<u>and</u>** functional criteria must be met, including the following:

1. **Diagnostic-** The person has an Axis I diagnosis (**note:** <u>not</u> just a diagnostic impression) of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin.
2. **Functional -** The individual's level of functioning has been significantly affected by the substance related disorder to the degree that there is a marked decrease in health and in ability to function. This decrease in health or in functioning must be demonstrated **<u>EITHER</u>** by ***both "a" and "b"*** below, **<u>OR</u>** ***by "c" alone.***

   a. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 1 level of care.

   --AND--

   b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or

her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.

--OR--

c. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 2 or above level of care.

G. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. **Adult Mental Health:**
    a. Schizophrenia and Other Psychotic Disorders
    b. Mood Disorders
    c. Anxiety Disorders
    d. Adjustment Disorders (By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor or its consequences)
    e. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
    f. **Exclusions:** The following disorders are ***excluded*** unless co-occurring with a qualifying primary Axis I mental or substance related disorder that is the focus of treatment:
        1. Tic disorders,
        2. Mental Retardation
        3. Learning Disorders
        4. Motor Skills Disorders
        5. Communication Disorders
        6. Organic Mental Disorders
        7. Pervasive Developmental Disorders
        8. Personality Change Due to a General Medical Condition
        9. Mental Disorder NOS Due to a General Medical Condition
        10. V Codes
2. **Adult Addictive Diseases**
    a. Substance-Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal.
    b. Note that severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
    c. **Exclusions:**
        1. Caffeine-Induced Disorders
        2. Nicotine-Related Disorders
        3. Substance Intoxication- only excluded for Ongoing Services.

NOTE*: The presence of co-occurring mental illnesses, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation.*

*Consumers diagnosed with the excluded Axis I mental disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I mental illness or substance related disorder. The qualifying Axis I mental illness or substance related disorder must be the presenting problem and the primary*

diagnosis/focus of treatment, and the consumer must meet the functional criteria listed above.

H. CONTINUED REVIEW OF ELIGIBILITY

Eligibility will be reviewed as consumers' MICP service reauthorizations become due.

Mental Health and Addictive Disease

Children and Adolescents' CORE Benefit Package

Community Support – Individual					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	H2015				
Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	H2015	UK			

Definition of Service: Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a child and family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the child. The service activities of Community Support include:

- Assistance to the child/youth and family/responsible caregivers in the development and coordination of the Individual Resiliency Plan (IRP);
- Planning in a proactive manner to assist the child/youth and family in managing or preventing in crisis situations;
- Individualized interventions, which shall have as objectives:
  1) Identification, with the child/youth, of strengths which may aid him or her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
  2) Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the child in order to assist that child/youth with recovery-based goal setting and attainment);
  3) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments);
  4) Encouraging the development and eventual succession of natural supports in school and other social environments;
  5) Assistance in the acquisition of skills for the child/youth to self-recognize emotional triggers and to self-manage behaviors related to the child's identified emotional disturbance;
  6) Assistance with personal development and school performance;
  7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the child's emotional disturbance;
  8) Service and resource coordination to assist the child/youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports;
  9) Assistance to children/youth and other supporting natural resources with illness understanding and self-management; and
  10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.
  11) Identification, with the child/youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided to children in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by

increased and/or stable participation in school. Supports based on the child's needs are used to promote resiliency while understanding the effects of the emotional disturbance and substance use/abuse and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, addiction, medical services, crisis prevention and intervention services.

Target Population	Children and Adolescents with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis, Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/ Developmental Disabilities
Benefit Information	*July 1, 2006-December 31, 2006:* Available to Core Customers for Brief Intervention and Stabilization for state-funded services (if the MICP I was submitted prior to June 30, 2006). Also available to Core Customers in need of Ongoing Services and in this instance requires a MICP Part I and/or MICP Part III *January 1, 2007-June 30, 2007*: Available to Core Customers in need of Ongoing Services. Requires a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	$16.69/unit
Initial Authorization	600 units
Re-Authorization	600 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 226 – C&A Mental Health 826 – C&A Addictive Diseases

Admission Criteria	1. Individual must meet target population criteria as indicated above; **and one or more of the following:** 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; **or** 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of Individualized Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in the individual's condition.
Service Exclusions	Intensive Family Intervention, Community Support-Team
Clinical Exclusions	1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: • mental retardation • autism • organic mental disorder, or • Traumatic brain injury

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
    - Symptom self-monitoring and self-management of symptoms
    - Strategies and supportive interventions for avoiding out-of-home placement for children and building stronger family support skills and knowledge of the child or youth's strengths and limitations
    - Relapse prevention strategies and plans
2. Community Support Services focus on building and maintaining a therapeutic relationship with the child and facilitating treatment and resiliency goals.
3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.

4. Individuals receiving Community Support Services must be seen face-to-face a minimum of once every 30 days. Children/youth and families must also receive a telephone check in call once a month unless there have been 2 or more face-to-face contacts within the community. The child/adolescent consumer of service must clearly remain the target of service.
5. At lease 60% of community support services must be delivered face-to-face with the identified children receiving this service, and at least 80% of all face-to-face services must be must be delivered in non-clinic settings over the authorization period. Services delivered to the Children's LEVEL OF CARE program are not counted in the minimum offsite service requirement. The Community Support - Individual provider, through documentation, must demonstrate that a significant effort has been made to make a face-to-face contact with the child/adolescent outside the agency; however, when multiple attempts made to contact youth have failed and have been documented, Community Support - Individual may still be billed.
6. When Community Support - Individual supports children/youth participating in medication management as the primary focus of service, the following allowances apply:
    a. These children/youth are not counted in the offsite service requirement or the consumer-to-staff ratio.
    b. These children/youth are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
    c. These children/youth who are have increased symptoms, increased resource needs, or increased risk due to poor natural supports should be reconsidered for traditional CSI or CST.
7. When Community Support - Individual supports an individual participating in the Children's LEVEL OF CARE program:
    - Services must be focused on planning for the child's reintegration into the community;
    - Services or supports which are duplicative of treatment supports offered through the Children's LEVEL OF CARE placement may not be provided;
    - Services may be exempt from aforementioned monthly face-to-face contact requirements; however, there must be documented face-to-face contact with the child at least once every three (3) months, as well as monthly phone contacts to child's treatment setting provider and family (more frequent phone contacts may be billed if related to discharge planning).

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
    - Mental Health Professional (MHP)
    - Substance Abuse Manager (SAM)
2. Under the supervision of a Physician, an MHP, or a SAM, the following staff may also provide Community Support:
    - Certified Peer Specialists
    - Paraprofessional staff

3. Community Support - Individual providers must maintain a recommended consumer-to-staff ratio of 30 consumers per staff member and a maximum ratio of 50 consumers per staff member. Individuals who receive only medication management are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support - Individual services provided to children and youth must include coordination with family and significant others and with other systems of care such as the school system, juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
2. Community Support - Individual providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the child/youth in a way that may potentially embarrass the individual or breech the youth's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their school time, choosing inconspicuous times and locations to promote privacy).
3. The organization must have policies that govern the provision of services in natural settings and can document that it respects individuals' and/or families' right to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. Each Community Support - Individual provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and individuals are targeted for such efforts.
6. The organization must have a Community Support Organizational Plan that addresses the following:
    - Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
    - Description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, how case mix is managed, access, etc.
    - Description of the hours of operations as related to access and availability to the individuals served and
    - Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan

D. Service Accessibility

1. Agencies that provide Community Support Services must regularly provide individuals with contact information for appropriate crisis intervention services (i.e. the after hours crisis services telephone number).
2. Consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the LOCUS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.6. are no longer applied.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. When a non-face-to-face contact is provided, the H2015UK reporting mechanism shall be utilized.
2. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Crisis Intervention					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Crisis Intervention Service; Per 15 Minutes	H2011	U1			
Crisis Intervention Service; Per 15 Minutes	H2011	U2			

Definition of Service: Services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as a child and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the youth and his/her family/responsible caregiver(s) and/or significant other, as well as other service providers. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting (e.g. home, school, jail, hospital, clinic etc).

The current family-owned safety plan, if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the child and family's wishes/choices by following the plan as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Diagnostic Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of this service to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Children/Adolescents with Mental Health issues and/or Substance Related Disorders Children/Adolescents experiencing a severe situational crisis

Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	H2011 U1 $23.96/unit H2011 U2 $27.00/unit
Initial Authorization	16 units
Re-Authorization	16 units *Any use beyond 16 units will not be denied but will trigger an immediate retrospective review.*
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 221 – C&A Mental Health 821 – C&A Addictive Diseases
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; **and #2 and/or #3 are met:** 2. Youth has a known or suspected mental health diagnosis or Substance Related Disorder; **or** 3. Youth is at risk of harm to self, others and/or property. Risk may range from mild to imminent; **and one or both of the following:** 4. Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; **or** 5. Youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	The Crisis Service with the "U2" modifier may not be authorized or billed with IFI.
Clinical Exclusions	1. The individuals' presenting situation is not dangerous to self or others. 2. Severity of clinical issues precludes provision of services at this level of care.

Additional Service Criteria:

A. Required Components

1. H2011 U1 is provided in clinic-based settings.
2. H2011 U2 is provided in out-of-clinic settings.

B. Staffing Requirements

1. A Mental Health Professional (MHP), Substance Abuse Professional (SAP), Substance Abuse Manager (SAM), or staff under the supervision of an MHP or SAM must furnish Service.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.
2. This service must be billed as either In-Clinic or Out-of-Clinic Crisis Management/ Intervention for Medicaid recipients in accordance with A. above.

F. Reporting Requirements

1. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Diagnostic Assessment and Individualized Resiliency Planning					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Mental Health Assessment, by Non-Physician	H0031				
Mental Health Service Plan Development by Non-Physician	H0032				
PSYCHOLOGICAL TESTING: Psychodynamic assessment of emotionality, intellectual abilities, personality and psychopathology; e.g., MMPI, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)	96101	AH			
PSYCHOLOGICAL TESTING: Psychodynamic assessment of emotionality, intellectual abilities, personality and psychopathology; e.g., MMPI, Rorschach, WAIS with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face	96102				

Definition of Service: Children/Families access this service when it has been determined through an initial screening that the youth has mental health or addictive disease needs. The initial Diagnostic Assessment and resulting Individualized Recovery/Resiliency Plan are required within the first 30 days of service, with ongoing Diagnostic Assessments and plans completed as demanded by individual consumer need and/or by service policy.

The Diagnostic Assessment and Individualized Recovery/Resiliency Planning process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective, and should include family and/or significant others as well as collateral agencies/treatment providers/relevant individuals.

The purpose of the Diagnostic Assessment process is to perform a formalized assessment in order to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to develop or review collateral assessment information. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

Information from the diagnostic assessment should ultimately be used to develop, together

with the child and caretakers an Individualized Resiliency Plan that supports resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. As indicated, medical, nursing, peer, school, nutritional, etc staff should inform the assessment and resulting IRP.

The cornerstone component of the child and adolescent Diagnostic Assessment and resulting Individualized Resiliency Plan (IRP) involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g. the child having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the child/adolescent based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual child and parent(s)/responsible caregiver(s) guiding these process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them.

The entire process should involve the child/youth as a full partner and should focus on service and resiliency goals/outcomes as identified by the individual and his/her family.

Target Population	A known or suspected mental health diagnosis and/or Substance-Related Disorder.	
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Part I and possibly a MICP Part III.	
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential	
Unit Value	H0031 and H0032	Unit=15 minutes
	96101 AH and 96102	Unit=1 hour
Reimbursement Rate	H0031 and H0032	$23.56
	96101 AH and 96102	$94.24
Initial Authorization	If a MICP Part I is submitted only-8 units If a MICP Part III is submitted with a Part I-16 units	
Re-Authorization	16 units	
Authorization Period	180 days	
UAS: **Budget and Expense Categories**	Core Services Provider 220 – C&A Mental Health 820 – C&A Addictive Diseases	
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; **and** 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency	

	planning; **and** 3. Youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year.
2. There may be no more than 4 combined hours of 96101 and 96012 provided to one individual within a six-month period.

B. Staffing Requirements

1. Diagnostic Assessment and Individualized Planning services are performed by a Mental Health Professional, Substance Abuse Professional, Substance Abuse Manager, or Certified Addiction Counselor II.
2. Psychological Testing services must be performed in accordance with the Georgia practice acts.

C. Clinical Operations

1. The individual consumer (and caregiver/responsible family members etc as appropriate) should actively participate in the assessment and planning processes.
2. The Individualized Resiliency Plan should be directed by the individual's/family's personal resiliency goals as defined by them.
3. Safety planning should be directed by the youth/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is therefore not likely to follow through with.

D. Service Access

E. Additional Medicaid Requirements

1. These services are performed by a Mental Health Professional, Substance Abuse Professional, Substance Abuse Manager, or Certified Addiction Counselor II or in accordance with GA Practice Acts related to Psychological Testing.

2. Nutritional Assessments which were billed to this service code prior to July 1, 2006 shall no longer be encompassed under this code. Please see the Nursing Assessment Code.

F. Reporting Requirements

1. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DMHDDAD.
2. In addition to the authorization and Individualized Resiliency Plan produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart as a Comprehensive Assessment.

Family Training/Counseling					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Counseling and Therapy, Per 15 minutes	H0004	HS			
Behavioral Health Counseling and Therapy, Per 15 minutes	H0004	HR			
Family Psychotherapy w/o the patient present (appropriate license required)	90846				
Conjoint Family Psychotherapy with the Patient Present (appropriate license required)	90807				
Skills Training and Development, per 15 minutes	H2014	HR			
Skills Training and Development, per 15 minutes	H2014	HS			

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner (a licensed therapist may conduct both counseling and training types of services/activities). Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family training/counseling provides systematic interactions between the identified individual consumer, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific therapeutic interventions/activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed/helping a family member to take medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills;
6) family roles and relationships;
7) daily living skills;
8) resource access and management skills; and
9) the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery/resiliency, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders

Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential
Initial Authorization	If a MICP Part I is submitted only-24 units If a MICP Part III is submitted with a Part I- 60 units
Reauthorization	60 units
Unit Value	15 minutes
Reimbursement Rate	$20.78
UAS: **Budget and Expense Categories**	Core Services Provider 230 – C&A Mental Health 830 – C&A Addictive Diseases
Admission Criteria	1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; **and** 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and individual is in imminent danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in individual's condition; **or** 5. Individual requires more intensive services.
Service Exclusions	Crisis Residential and Intensive Family Intervention

Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, and organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.
2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the family for whom the service is being provided.

B. Staffing Requirements

1. Family training is provided by or under the supervision of a Mental Health Professional or a Substance Abuse Manager. A Mental Health Professional or a Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services must provide family counseling.
2. Training and Counseling should be differentiated by practice and practitioner. When the aforementioned services are addressed through didactic training, structured practice, coaching techniques, etc., a practitioner may include those with licenses to provide counseling (O.C.G.A. Practice Acts) and other paraprofessionals. Only a licensed clinician may perform family counseling when the intervention includes techniques involving the principles, methods and procedures of counseling that assist the family in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Modes of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

3. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Group Training/Counseling					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Counseling and Therapy, Per 15 Minutes	H0004	HQ			
Behavioral Health Counseling and Therapy, Per 15 Minutes	H0004	HQ	HR		
Behavioral Health Counseling and Therapy, Per 15 Minutes	H0004	HQ	HS		
Skills Training and Development, Per 15 Minutes	H2014	HQ			
Skills Training and Development, Per 15 Minutes	H2014	HQ	HR		
Skills Training and Development, Per 15 Minutes	H2014	HQ	HS		
Group Psychotherapy Other Than of a Multiple Family Group (appropriate license required)	90853				

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills;
6) daily living skills;
7) resource management skills;
8) knowledge regarding emotional disturbance, substance related disorders and other relevant topics that assist in meeting the youth's and family's needs; and
9) skills necessary to access and build community resources and natural support systems.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.

Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential
Initial Authorization	If a MICP Part I is submitted only-24 units If a MICP Part III is submitted with a Part I- 200 units
Re-Authorization	200 units
Unit Value	Unit=15 minutes
Reimbursement Rate	$14.30
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 229 – C&A Mental Health 829 – C&A Addictive Diseases
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Youth continues to meet admission criteria; **and** 2. Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Resiliency Plan have been substantially met; **or** 3. Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; **or** 4. Transfer to another service/level of care is warranted by change in youth's condition; **or** 5. Youth requires more intensive services.
Service Exclusions	Crisis Residential See also below, Item A.2.

Clinical Exclusions	1. Severity of behavioral health issue precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency building plans and interventions.
2. Extended groups are not allowed under this service code. Any services in excess of 2 hours in a given day may be subject to scrutiny by the external review organization.
3. Group outpatient services should very rarely be offered in addition to day services. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day support/treatment activities.
4. When billed concurrently with IFI services, this service must focus on group counseling rather than training, and counseling must be curriculum based. Groups for IFI service recipients cannot include non-IFI service recipients.

B. Staffing Requirements

1. Training is provided by or under the supervision of a Mental Health Professional or a Substance Abuse Manager. A Mental Health Professional or a Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services must provide group counseling. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance.
2. Training and Counseling should be differentiated by practice and practitioner. When the aforementioned services are addressed through didactic training, structured practice, coaching techniques, etc., a practitioner may include those with licenses to provide counseling (O.C.G.A. Practice Acts) and other paraprofessionals (including Certified

Peer Specialists). Only a licensed clinician may perform group counseling when the intervention includes techniques involving the principles, methods and procedures of counseling that assist the group in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns.

3. Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

C. Clinical Operations

1. Community-based group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Individual Counseling					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, approximately 20-30 minutes, face-to-face with the patient (appropriate license required)	90804				
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, approximately 45-50 minutes, face-to-face with the patient (appropriate license required)	90806				
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, approximately 75-80 minutes, face-to-face with the patient (appropriate license required)	90808				
Individual Psychotherapy, Interactive, Using Play Equipment, physical devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, in an Office or Outpatient Facility, Approximately 20-30 Minutes, Face-to-Face with the Patient (appropriate license required)	90810				
Individual Psychotherapy, Interactive, Using Play Equipment, physical devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, in an Office or Outpatient Facility, Approximately 45-50 Minutes, Face-to-Face with the Patient (appropriate license required)	90812				
Individual Psychotherapy, Interactive, Using Play Equipment, physical devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, in an Office or Outpatient Facility, Approximately 75-80 Minutes, Face-to-Face with the Patient (appropriate license required)	90814				

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized

Resiliency Plan. These services address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

1) the illness/emotional disturbance and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills; and
6) knowledge regarding the emotional disturbance, substance related disorders and other relevant topics that assist in meeting the youth's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, Interactive Play Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Children/Adolescents with a Mental Illness/Emotional Disturbance and/or Substance-Related Disorders	
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.	
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential	
Unit Value	Unit=1 encounter	
Reimbursement Rate	90804, 90810	$34.70
	90806, 90812	$62.46
	90808, 90814	$104.10
Initial Authorization	24 units	
Re-Authorization	24 units	
Authorization Period	180 days	
UAS: **Budget and Expense Categories**	Core Services Provider 228 – C&A Mental Health 828 – C&A Addictive Diseases	

Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. The youth's resiliency goal that is to be addressed by this service must be conducive to response by an individual therapeutic milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Individual demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. Adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in individual's condition; **or** 5. Individual requires a service approach which supports less or more intensive need.
Service Exclusions	Crisis Residential and Intensive Family Intervention
Clinical Exclusions	1. Severity of behavioral health disturbance precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.

B. Staffing Requirements

1. A Mental Health Professional or Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services must provide Individual Counseling.
2. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Medication Administration					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Comprehensive Medication Services	H2010				
Therapeutic, Prophylactic or Diagnostic Injection (Specify Material Injected, Subcutaneous or Intramuscular)	90772				
Alcohol and/or Drug Services; Methadone Administration and/or Service (Provision of the drug by a licensed program)	H0020				

Definition of Service: The giving or administration of an oral medication or injection. Medication administration requires a physician's order, and licensed medical personnel under the supervision of a physician must administer medication. The service must include:

1. An assessment, by the licensed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review.
2. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan.

This service may also include the administration of medication for opioid/methadone maintenance in accordance with state law (see also Opioid Maintenance Code).

Target Population	Youth with SED Youth with Substance Related Disorders Youth with Co-occurring SED and Substance Related Disorders Youth with Co-occurring SED and MR/DD (if the medications are related to the SED issue) Youth with Co-occurring Substance Related Disorders and MR/DD (if the medications are related to the substance use/abuse issue)
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.

Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential
Unit Value	Unit=1 encounter
Reimbursement Rate	$24.67
Initial Authorization	With the submission of MICP Part I only-12 units With the submission of MICP Part I and III: H0020= 180 units 90772= 18 units H2010= 60 units
Re-Authorization	H0020= 180 units 90772 = 18 units H2010= 60 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 224 – C&A Mental Health 824 – C&A Addictive Diseases
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places self/others in danger) or distressing (causes mental anguish or suffering); **and** 2. Youth/family is unable to self-administer/administer prescribed medication because: a. Although the youth is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; **or** b. Although youth is willing to take the prescribed medication, it is a Class A controlled substance (e.g. Methadone) which must be stored and dispensed by medical personnel in accordance with state law; **or** c. Due to severity of the emotional disturbance/substance related disorder, youth is unwilling/unable to administer needed medication; **or** d. Due to the family/caregiver's lack of capacity and/or age of the youth, there is no responsible party to self-manage/manage self-administration of medication; **and** e. As evidenced by the youth's history, the individual would likely be in danger of harm to self, others or property without the medication
Continuing Stay Criteria	1. Youth continues to meet admission criteria. 2. If methadone is indicated, individual must meet criteria

	established by the Georgia Regulatory body for methadone administration programs (Department of Human Resources-DMHDDAD) and the Food and Drug Administration's guidelines for this service.
Discharge Criteria	1. Youth no longer needs medication; or 2. Youth/Family/Caregiver is able to self-administer/administer medication; or 3. Must meet criteria established by the Georgia Regulatory body for methadone administration programs (Department of Human Resources- DMHDDAD) and the Food and Drug Administration's guidelines for this service; and 4. Adequate continuing care plan has been established.
Service Exclusions	1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment or Crisis Residential. 3. Must not be billed while enrolled in CSP except if this Medication Administration service is utilized only for the administration of methadone (for Medicaid recipients). 4. For Medicaid recipients who need opioid maintenance, this service should be utilized in place of Opioid Maintenance.

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the youth's chart. Telephone orders are acceptable provided they are co-signed by the physician in accordance with DMHDDAD standards.
2. Documentation must support that the individual is being trained in the risk and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support that the youth AND family/caregiver is being trained in the principle of self-administration of medication or that the youth/family/caregiver is physically or mentally unable to self-administer/administer. This documentation may be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
4. This service does not include the supervision of self-administration of medication.
5. An agency that administers methadone must meet criteria established by the Georgia regulatory body for methadone administration programs (Department of Human Resources –DMHDDAD) and the Food and Drug Administrations guidelines for this service.

B. Staffing Requirements

1. Medication must be administered by licensed medical personnel under the supervision of a physician.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients who need opioid maintenance, this service should be utilized in place of Opioid Maintenance.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Nursing Assessment and Health Services					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Nursing Assessment/Evaluation (15 minutes)	T1001				
RN Services, 15 minutes	T1002				
LPN/LVN Services, 15 minutes	T1003				
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psychphysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, initial assessment	96150				
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psychphysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, re-assessment	96151				

Definition of Service: This service requires face-to-face contact with the youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or physical problems and general wellness of the youth. It includes:

1) Providing nursing assessments to observe, monitor and care for the physical, nutritional and psychological issues, problems or crises manifested in the course of an youth's treatment;
2) Assessing and monitoring the youth's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the youth to a physician for a medication review;
3) Assessing and monitoring a youth's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
4) Consulting with the youth's family/caregiver about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
5) Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc);
6) Training for self-administration of medication; and
7) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by a Licensed Physician, Physician Assistant or Advanced Practice Nurse.

Target Population	Youth with Mental Health issues/SED and/or Substance Related Disorders Individuals with Mental Health issues/SED and MR/DD Individuals with Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	$24.44
Initial Authorization	With the submission of MICP Part I only-12 units With the submission of MICP Part I and III- 60 units
Re-Authorization	60 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 223 – C&A Mental Health 823 – C&A Addictive Diseases
Admission Criteria	1. Youth presents symptoms that are likely to respond to medical/nursing interventions; **or** 2. Youth has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Youth continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; **or** 2. Youth exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; **or** 3. Youth demonstrates progress relative to medical/medication goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Youth no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; **or** 3. Goals of the Individualized Resiliency Plan have been substantially met; **or** 4. Youth/family requests discharge and youth is not in imminent danger of harm to self or others.
Service Exclusions	Ambulatory Detoxification and Crisis Residential.
Clinical Exclusions	Routine nursing activities that are included as a part of ambulatory

	detoxification and medication administration/methadone administration.

Additional Service Criteria:

A. Required Components

1. Nutritional assessments indicated by a youth's confounding health issues might be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Registered Clinical Dietician.
2. This service does not include the supervision of self-administration of medication.

B. Staffing Requirements

1. These services must be offered by a licensed nurse within the scope of O.C.GA Practice Acts.
2. Practitioners providing this service are expected to maintain and utilize knowledge and skills regarding current research trends in best/evidence-based practices for psychiatric nursing and medication management.

C. Clinical Operations

1. Venipuncture billed under this service must include documentation that includes cannula size utilized, insertion site, number of attempts, location, and consumer tolerance of procedure.
2. All nursing procedures must include relevant consumer-centered, family-oriented education regarding the procedure.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Pharmacy

Definition of Service: Directly or through a subcontract, prepare, compound, preserve, store, protect, and dispense prescribed medications; and assure appropriate instructions are provided as to the use of prescribed medications. These functions are coupled with youth, family/caregiver and staff education and pharmacological monitoring to ensure safe and effective use of prescribed medications.

Target Population	Youth with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers with emphasis on priority populations. Requires a MICP Part I and possibly a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	
Reimbursement Rate	
Initial Authorization	
Re-Authorization	
Authorization Period	
UAS: Budget and Expense Categories	Core Services Provider 290 – C&A Mental Health 890 – C&A Addictive Diseases
Admission Criteria	Youth has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication.
Continuing Stay Criteria	Youth continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Youth no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; **or** 2. Youth and family/caregiver request discontinued access to this service and youth is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.
2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs which promote consumer access in obtaining medication.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not a Medicaid Rehabilitation Option service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting Requirements

a. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

Physician Assessment and Care					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Psychiatric Diagnostic Interview Examination (physician only)	90801				
Psychiatric Diagnostic Interview Examination (physician only)	90801	HA			
Psychiatric Diagnostic Interview Examination	90801	U3			
Psychiatric Diagnostic Interview Examination	90801	HA	U3		
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication (Physician only)	90802				
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication	90802	U3			
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication (Physician only)	90802	HA			
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication (Physician only)	90802	HA	U3		
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes (Physician only)	90805				
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes	90805	U3			
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes (Physician only)	90805	HA			
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an	90805	HA	U3		

Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes (Physician only)			
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes (Physician only)	90807		
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes	90807	U3	
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes (Physician only)	90807	HA	
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes (Physician only)	90807	HA	U3
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862		
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862	HA	
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862	GT	
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862	GT	HA
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	U3	
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	HA	U3

Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	GT	U3	[redacted]	[redacted]
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	GT	HA	U3	[redacted]

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

a. Evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues) drawing from youth report and family report,
b. A psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis),
c. Medical or psychiatric therapeutic services,
d. Assessment and monitoring of the youth's status in relation to treatment with medication, the development and authorization of the proposed support service array,
e. Assessment of the appropriateness of initiating or continuing services, and
f. Screening and/or assessment of any withdrawal symptoms for youth with substance related diagnoses.

Youth must receive appropriate medical interventions as prescribed and provided by a physician (or physician extender) that shall support the individualized goals of resiliency as identified by the youth/family/caregiver and their Individualized Resiliency Plan.

Target Population	Youth with Mental Illness or Substance Related Disorders	
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part III.	
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential	
Unit Value	Unit=1 encounter	
	90801HA, 90802HA	$132.13
	90801HAU3, 90802HAU3	$112.31
	90805HA	$92.49
	90805HAU3	$78.62
	90807HA	$132.10
	90807HAU3	$112.28
	90862HA, 90862GTHA	$52.85
	90862HAU3, 90862GTHAU3	$44.92
Initial Authorization	12 units	
Re-Authorization	12 units	
Authorization Period	180 days	

UAS: **Budget and Expense Categories**	Core Services Provider 222 – C&A Mental Health 822 – C&A Addictive Diseases
Admission Criteria	1. Youth has a mental illness or a substance-related disorder and has recently entered the service system; **or** 2. Individual is in need of annual assessment and re-authorization of service array; **or** 3. Individual has been prescribed medications as a part of the treatment array; **or** 4. Individual has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; **or** 5. Individual has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	1. Individual continues to meet the admission criteria; **or** 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; **or** 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; **or** 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual has withdrawn or been discharged from service; **or** 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	Not offered in conjunction with Intensive Day Treatment, ACT, or Crisis Stabilization Programs.
Clinical Exclusions	Services defined as a part of ambulatory detoxification, ACT, Crisis Stabilization Programs, and Intensive Day Treatment.

Additional Service Criteria:

A. Required Components

1. The "GT" code modifier refers to live telemedicine via videoconference link (i.e. video phones, web cams, etc.). It requires the presence of both parties at the same time. Audio and video must be involved with remote support sometimes also being present (but not billable simultaneously).
2. Telemedicine may not be utilized for an initial physician's assessment, but shall be utilized for ongoing physician evaluation and management.

B. Staffing Requirements

1. Practitioners providing this service are expected to maintain and utilize knowledge and skills regarding current research trends in best/evidence-based practices for psychiatry and medication management.
2. This service must be provided by a licensed medical physician with behavioral health training in accordance with the O.C.G.A and the Professional Practice Acts (excepting B.3.).
3. This service may also be provided by a Clinical Nurse Specialist or a Physician's Assistant with behavioral health training in accordance with O.C.G.A and the Professional Practice Acts. If an extender is used, other physician codes on the same day may only be used when the extender's notes identify the need for validation of clinical judgment. These interventions shall not be duplicative in nature.

C. Clinical Operations

1. It is expected that youth and families will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with youth and families and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure to the youth is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the youth's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). The family/caregiver's role is an essential component of this dialogue.

D. **Service Access**

1. Telecommunications may be used to provide the service if the code has a GT modifier and if the remote site is designated as a Health Professional Shortage Area.

E. Additional Medicaid Requirements

1. For Medicaid recipients, only a licensed medical physician as described in the staffing requirements above may provide this service.
2. Currently, there are no other additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Mental Health and Addictive Disease

Children and Adolescents' SPECIALTY Benefit Package

Activity Therapy					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Activity Therapy; Per 15 Minutes	H2032	HA			

Definition of Service: The intentional and systematic use of recreational therapy, music therapy, art therapy, psychodrama, drama therapy, dance/movement therapy, biblio/poetry therapy, equestrian therapy, and/or horticultural therapy to treat the identified psychosocial, emotional, cognitive and rehabilitative needs of the individual. This service is offered for a maximum of 2 hours per day.

Expected outcomes for children and adolescents with serious emotional disturbances and/or substance-related diagnoses are improved interpersonal relationships and social skills, attention and concentration, ability to express feelings, and leisure functioning; reduced anxiety and tension; decreased aggressive behaviors; distraction from negative symptoms of mental illness; and strengthening of social/natural supports in the community.

Target Population	Children and Adolescents with SED and/or Substance Related Disorders
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part III
Utilization Criteria	Available to those with CAFAS scores: 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	$11.88/unit
Initial Authorization	300 Units
Re-Authorization	300 Units
Authorization Period	90 days
UAS: **Budget and Expense Categories**	C&A Activity Services Provider 261 – C&A Mental Health 861 – C&A Addictive Diseases

Admission Criteria	1. Youth has primary behavioral health issues that are distressing (causing mental anguish or suffering) or destabilizing (markedly interfering with the ability to carry out daily activities or placing self/others in potential danger); **and one or more of the following:** 2. Youth lacks skill in the independent, successful use of leisure time, resulting in a barrier to community-based placement; **or** 3. Youth has received services through other services modalities and needs additional or different supports and/or structure.
Continuing Stay Criteria	1. Youth must have primary behavioral health issues that are distressing (causing mental anguish or suffering) or destabilizing (markedly interfering with the individual's ability to carry out daily activities or places self/others in potential danger); **and one or more of the following:** 2. Youth lacks skill in the independent, successful use of leisure time resulting in a barrier to community-based placement; **or** 3. Youth has received services through other service modalities and needs additional or different supports and/or structure. In addition, the individual must be showing progress toward resiliency goals as a result of initial activity therapy support.
Discharge Criteria	1. An adequate continuing care or discharge plan has been established **and one or more of the following:** 2. Youth no longer meets the admission criteria or continuing stay criteria; **or** 3. Goals of the Individualized Resiliency Plan have been substantially met; **or** 4. Youth and family request discharge, and the youth is not imminently dangerous; **or** 5. Transfer to another service/level of care is warranted by change in the individual's condition; **or** 6. Youth requires services not available through this modality of service; **or** 7. Youth is unwilling to comply with the program or is not making satisfactory progress toward service plan goals.
Service Exclusions	Not offered in conjunction with C&A Day Treatment or SA Adolescent Day Treatment.
Clinical Exclusions	1. Youth who requires one-to-one supervision for protection of self or others. 2. Youth is actively using unauthorized drugs or alcohol. 3. Youth with a psychiatric/addiction condition requiring a more intensive support/service.

Additional Service Criteria:

A. Required Components

1. When group activity therapy is offered, the maximum face-to-face ratio cannot be more than 6 consumers to 1 direct service staff based on average daily attendance.

B. Staffing Requirements

1. The activity therapy service design for each youth must be approved by a credentialed professional in one of the specific disciplines listed below.
2. Activity Therapy must be provided by a qualified professional therapist who meets the established training standards and credentialing requirements of one of the following associations:

    - Art Therapy – The Art Therapy Credentials Board
      Credential: A.T.R. or A.T.R.-BC
    - Biblio/Poetry Therapy – Federation for Biblio/Poetry Therapy
      Credential: CPT or RPT
    - Dance/Movement Therapy – American Dance Therapy Association
      Credential: DTR or ADTR
    - Music Therapy – Certification Board for Music Therapists
      Credential: MT-BC
    - Drama Therapy – National Association for Drama Therapy
      Credential: RDT
    - Horticultural Therapy – American Horticultural Therapy Association
      Credential: HTR or HTM
    - Psychodrama – The American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy
      Credential: CP or TEP
    - Recreational Therapy – National Council for Therapeutic Recreation Certification
      Credential: CTRS

C. Clinical Operations

1. Reimbursement for occasional therapeutic outings is allowed. The supporting documentation describing the individual's participation in the therapeutic outing must reflect the relationship of the activity to a specific goal in the Individualized Resiliency Plan. Billing for any therapeutic outing must remain within the daily maximums for this service and must be within the authorized amount of approved service for the individual being served.
2. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. While a combination of day supports in a group setting and one-to-one activity therapy is acceptable if ordered as part of the Individualized Resiliency Plan, it is subject to retrospective review.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Child and Adolescent Mental Health Day Treatment					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Behavioral Health Day Treatment; Per Hour	H2012	HA	HE	U2	

Definition of Service: Specialized after-school and weekend group-based services including counseling (individual, group, family), parent/consumer education, skill/leisure/socialization training which focus on the amelioration of functional and behavioral deficits resulting from an emotional disturbance or co-occurring disorder. Services are to be available at least 5 days per week to allow youth's access to supports and treatment deemed necessary to build the youth's age-appropriate functioning within the community and family. Intense coordination/linkage with schools and other child serving agencies is mandatory. Child and Adolescent Mental Health Day Treatment provides stabilization of psychiatric concerns and promotes resiliency incorporating the basic tenets of clinical practice. This service is offered for a minimum of 2 hours per day and a maximum of 5 hours per day.

The programmatic goals of the service must be clearly articulated by the provider, utilizing population and issue-specific best/evidence based practices for service delivery and support (including addressing both mental health and co-occurring substance related disorders/issues). Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice models/components are Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, family education/training, and others as appropriate to the population(s) and issues to be addressed. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical services provided by a multidisciplinary team, and are directed towards the identified youth and his or her behavioral health needs based upon the Individualized Resiliency Plan.

Target Population	Children and Adolescents with SED Children and Adolescents with SED and Co-Occurring Substance Related Disorders.
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part III
Utilization Criteria	Available to those with CAFAS scores: 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Unit Value	Unit=1 hour
Reimbursement Rate	$19.18/unit
Initial Authorization	450 units (unit = 1 hour)
Re-Authorization	450 units (unit = 1 hour)
Authorization Period	90 days

UAS: **Budget and Expense Categories**	C&A Day Services Provider 256 – C&A Mental Health
Admission Criteria	1. Youth can reasonably be expected to show demonstrable improvement within 6 months; **and one or more of the following:** 2. Youth must have incapacitating mental health issues that interfere with the ability to carry out daily activities and/or place others in danger to the point of causing anguish or suffering; **or** 3. Youth's clinical and behavioral issues are unmanageable in traditional outpatient treatment and require intensive, coordinated multidisciplinary intervention within a therapeutic milieu; **or** 4. Youth's level of functioning precludes provision of services in less restrictive services/supports and includes deficits in daily living skills, social skills, vocational/academic skills, and community/family integration.
Continuing Stay Criteria	1. If services are discontinued there would be an increase in the severity of the presenting problems; **or** 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but the goals are not yet met.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Resiliency Plan have been substantially met; **or** 3. Youth and family request discharge, and the youth is not imminently dangerous; **or** 4. Transfer to another service/level of care is warranted by change in the youth's condition; **or** 5. Youth requires services not available in this level of care.
Service Exclusions	Not offered at the same time as SA Adolescent Day Treatment or Activity Therapy.

Clinical Exclusions	1. Youth who requires one-to-one supervision for protection of self or others; **or** 2. Youth with severe clinical issues (i.e. that warrant hospitalization) that preclude provision of services at this service intensity; **or** 3. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder d. Primary Substance Abuse Problems; **or** 4. Youth is actively using unauthorized drugs or alcohol; **or** 5. Youth can be effectively and safely treated at a lower intensity of service.

Additional Service Criteria:

A. Required Components:

1. The service must operate at an established clinic site. However, appropriate therapeutic recreational activities may take place off-site in natural community settings in accordance with the youth's specific resiliency goal(s).
2. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space.
3. Programming must complement and coordinate with the school system and/or DFCS, DJJ as clinically necessary.

B. Staffing Requirements

1. Maximum face-to-face ratio cannot be more than 4 youth to 1 direct service staff based on average daily attendance.
2. The program is under the supervision of a Mental Health Professional.
3. The staff consists of at least 50% Mental Health Clinicians and/or Mental Health Professionals.
4. While SAP/SAM staff are not required for this service, the agency offering services to children and adolescents with co-occurring MH/AD issues must document that at least one staff have either experience in serving this population or have received 4 hours of co-occurring competency training within the last 2 years. This documentation shall be maintained in staff personnel records.

C. Clinical Operations

1. Transition planning for less intensive service options is expected to begin at the onset of this service delivery. Documentation must demonstrate this planning.

2. While Family Training and Individual Counseling are included in this service, Family Therapy may be offered as a separate and concurrent service.
3. Involvement of parents/caretakers is essential in the provision of specialized day services for children and adolescents and is a necessary tool in enabling the individual to move to less restrictive services. This requirement, however, should not be allowed to become a barrier to the delivery of services to individuals whose parent/s or caretaker/s are not able to participate or are not available.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In addition to other reporting requirements, daily progress notes are required because of the intensity of this service.

Community Based Inpatient Psychiatric and Substance Detoxification Services					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Psychiatric Health Facility Service, Per Diem	H2013				

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Children and Adolescents with a SED Children and Adolescents with a Substance Related Disorder Children and Adolescents with Co-occurring SMI and a Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services and requires MICP Part III
Utilization Criteria	Available to those with CAFAS scores: 190-240: Medically Managed Inpatient Residential (transition)
Unit Value	Per Diem
Reimbursement Rate	Per negotiation
Initial Authorization	5 days
Re-Authorization	3 days
Authorization Period	5 days
UAS: **Budget and Expense Categories**	C&A Crisis Services Provider 235 – C&A Mental Health 835 – C&A Addictive Diseases
Admission Criteria	1. Youth with SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Youth's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Youth is assessed as meeting diagnostic criteria for a Substance Induced Disorder according to the latest version of the DSM; and one or more of the following: A. Youth is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the

	youth, as evidenced by: i. A detoxification regimen or Youth's response to that regimen that requires monitoring or intervention more frequently than hourly, or ii. The youth's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.
Continuing Stay Criteria	1. Youth continues to meet admission criteria; and 2. Youth's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer meets admission and continued stay criteria; or 3. Family requests discharge and youth is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.
Clinical Exclusions	Youths with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2
2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

1. Only nursing or other licensed medical staff under supervision of a physician may provide detoxification services.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service.

F. Reporting Requirements

1. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

Community Support – Team

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	H2015	HT			

Definition of Service: Community Support Team is a resiliency oriented, intensive, community-based service available 24 hours per day, 7 days per week, that provides treatment and restorative/resiliency focused interventions to assist youth in gaining access to necessary services; in managing (including teaching skills to self-manage) their emotional disturbance and/or substance use/abuse issues, in developing optimal age-appropriate community living skills, and in setting and attaining consumer and family defined resiliency goals. Services are provided utilizing a team approach, and must be documented in the Individualized Resiliency Plan (IRP). Based upon the goals and needs of the individual, services may include:

1) Assistance to the youth/family in the development of the Individualized Resiliency Plan (IRP);
2) Psychoeducational and instrumental support to children/youth and their families; and
3) Crisis assessment, support and intervention; and
4) Individualized interventions, which may include:
    a. Identification, with the child/youth, of strengths which may aid him or her in enhancing resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
    b. Support to facilitate enhanced natural and age-appropriate supports (including emotional/therapeutic support/assistance with defining what wellness means to the child in order to assist child/youth with recovery-based goal setting and attainment);
    c. Service and resource coordination to assist the child/youth in gaining access to necessary rehabilitative, medical, social and other services and supports;
    d. Family counseling/training for children/youth and their families (as related to the child's IRP);
    e. Individualized, restorative one-to-one therapeutic interventions to develop interpersonal/social, community coping and age-appropriate functional skills (including adaptation to home, school and healthy social environments);
    f. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues;
    g. Assistance to children/youth and other supporting natural resources with illness understanding and self-management;
    h. Assistance with personal development and school performance particularly in areas in which the behavioral health issue has created challenges;
    i. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psychoeducational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc); and

j. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs.

Community Support Teams may serve as a step down service for youth transitioning from Intensive Family Intervention services or other higher levels of care, or for those with psychiatric hospitalizations/repeated substance use/abuse incidence in the past 18 months. The service is provided to children/youth to decrease hospitalizations and crisis episodes and increase community/school tenure; age-appropriate functioning; increase healthy social contacts; and personal satisfaction and autonomy. Through supports based on identified, individualized needs, the child/youth will reside in with caregivers in natural home settings and be engaged in the support process.

Target Population	Children and Adolescents experiencing: SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and SED Co-Occurring SED and Mental Retardation/DD Co-occurring Substance-Related Disorders and Mental Retardation/DD
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part III.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	$20.11/unit
Initial Authorization	480 units
Re-Authorization	480 units *Continued Stay Review is required every 180 days.*
Authorization Period	180 days
UAS: **Budget and Expense Categories**	<u>Intensive Treatment Services Provider</u> 251 – C&A Mental Health 851 – C&A Addictive Diseases
Admission Criteria	Individuals with moderate to severe symptoms, **and 4 or more of the following conditions:** • High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 2 or more admissions per year), or extended hospital stay (30 days within the past year), or psychiatric emergency services. • High use of substance abuse services (e.g. 2 or more episodes per year) • History of inadequate follow-through with elements of a Resiliency Plan related to risk factors, including lack of

	follow-through taking medications, following a crisis plan, or maintaining family integration. • Medication resistant due to intolerable side effects or illness prohibits consistent self-management of medications. • Legal issues such as continued involvement with juvenile court systems. • Child and/or family behavioral health issues have not shown improvement in traditional outpatient treatment and require coordinated clinical and supportive interventions. • Because of behavioral health issues, the child has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent • Clinical evidence of suicidal gestures and/or ideation in past 3 months. • Ongoing inappropriate public behavior within the last 3 months. • Self-harm or threats of harm to others within the last year. • Evidence of significant complications such as cognitive impairment, behavioral problems, or medical conditions. • A lower service intensity has been tried or considered and found inappropriate at this time.
Continuing Stay Criteria	1. Same as above.
Discharge Criteria	3. An adequate continuing care plan has been established; **and one or more of the following:** 4. No longer meets admission criteria; **or** 5. Goals of the Individualized Resiliency Plan have been substantially met **or**; 6. Youth and family request discharge and youth is not in imminent danger of harm to self or others; **or** 7. Transfer to another service/level of care is warranted by change in youth's condition; **or** 8. Youth requires services not available in this level of care.
Service Exclusions	Not offered in conjunction with Intensive Family Intervention.
Clinical Exclusions	1. Presence of any psychiatric condition requiring a more intensive level of care. 2. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. Community Support Teams offer a comprehensive set of psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team provides community support services that are interwoven with rehabilitative efforts.
2. Services and interventions are highly individualized and tailored to the needs and preferences of the individual, with the goal of maximizing age-appropriate behaviors and supporting resiliency and behavioral wellness.
3. The Community Support Team must see each consumer, at a minimum, twice a month, with one encounter focusing on symptom assessment/management and management of medications. Youth/families must also receive a telephone check-in call once a month.
4. At least 60% of services are provided face-to-face with youth and 80% of all face-to-face services are delivered in non-clinic settings during the authorization period.
5. There must be bi-monthly staffings, attended by an MHP/SAM, which specifically discuss the status of each child/youth consumer enrolled in the service. Evidence of these staffings must be documented in each youth's chart/record.

B. Staffing Requirements

1. Minimum staffing requirements for a Community Support Team include the following:
    - Fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be licensed and/or credentialed (CACII).
    - Paraprofessionals who work under the supervision of either a Mental Health Professional or a Substance Abuse Manager and who work on the team in sufficient fulltime equivalents to meet the required consumer-to-staff ratio.
2. Community Support Teams must be comprised of a minimum of 3 and a maximum of 4 staff members meeting the requirements above (including the FTE MHP/SAM Team leader).
3. The Community Support Team maintains a recommended consumer-to-practitioner ratio of no more than 18 consumers per staff member. Staff-to-consumer ratio takes into consideration evening, weekend and holiday hours, needs of special populations, and geographical areas to be served.
4. Documentation must demonstrate that at least 2 team members are actively engaged in the support of each consumer served by the team. One of these team members must be appropriately licensed/credentialed (CACII) to provide any professional counseling and treatment modalities/interventions needed by the consumer and must provide these modalities/interventions as clinically appropriate according to the needs of the consumer.

C. Clinical Operations

1. Community Support Team services provided to children and youth must include coordination with family and significant others and with other systems of care such as school system, juvenile justice system, and children's protective services when appropriate to treatment and educational needs.

2. Community Support Team providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that youth/families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the youth in a way that may potentially embarrass the child/youth or breech the youth's privacy/confidentiality. Staff should be sensitive to and respectful of children/families privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their school time, choosing inconspicuous times and locations to promote privacy
3. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. Each Community Support Team provider must have policies and procedures for the provision of community-based services, including means by which these services and individuals are targeted for such efforts. The organization also must have policies and procedures for protecting the safety of staff that engage in these activities.
6. The organization must have a Community Support Team Organizational Plan that describes:
    - Particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
    - Staffing pattern and how staff is deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated
    - Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)
    - Hours of operation, the staff assigned and types of services provided to consumers, families, and/or guardians
    - How the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan.
7. For youth with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.

D. Service Accessibility

1. This service must be available 24 hours a day, 7 days a week with emergency response coverage. The team must be able to rapidly respond to early signs of behavioral crisis. An on-call CST staff member skilled in crisis intervention must provide coverage.
2. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Consumer/Family Assistance

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Mental Health Services, Not Otherwise Specified	H0046				

Definition of Service: Children and families may need a range of goods and community support services to fully benefit from mental health and addictive disease services. This time-limited service consists of goods and services purchased/procured on behalf of the consumer (e.g. purchase of a time-limited behavioral aide or mentor, a one-time rental payment to prevent eviction/homelessness, a utility deposit to help stabilize a child's behavioral health crisis, environmental modification to the individual's home to enhance safety and ability to continue living independently etc) that will help promote support to the youth's responsible family member(s)/responsible caregiver(s)/legal guardian to the benefit of the individual and his/her behavioral health stability. The goods/services procured must provide a *direct and critical* benefit to the individualized needs of the child/youth, in accordance with the IRP, and lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution or out-of-home placement, or prevent an imminent crisis or out-of home placement (e.g. eviction, homelessness, loss of caregiver/family/guardian's ability to maintain the youth living in the home, hospitalization/institutionalization, etc). The service is not intended to pay for/provide ongoing service programming through the provider agency.

Target Population	Children or Adolescents defined as Core Customers of Ongoing Services who are diagnosed with: A Severe Emotional Disturbance Substance Related Disorders Co-Occurring SED and Substance Related Disorders Co-Occurring SED/Substance Related Disorders and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part III.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	Variable in accordance with Items C.6. below
Reimbursement Rate	Variable in accordance with Items C.6. below
Initial Authorization	While the actual assistance should be very short-term in nature, this service can be authorized as part of a 180 day Individualized Resiliency plan. Financial max $5000
Re-Authorization	One within a single fiscal year.

Authorization Period	180 days
UAS: **Budget and Expense Categories**	Consumer/Family Support Services Provider 237 – C&A Mental Health 837 – C&A Addictive Diseases
Admission Criteria	1. Youth must meet Core Customer criteria for Ongoing services, **and** 2. Youth or the youth's caregiver/responsible family members/legal guardian must be in need of a specific good or service that will directly improve functioning (e.g. directly lead to an enhancement of specific positive behaviors/skills/resources that will allow the youth to leave an institution or long-term residential placement), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of caregiver's/family's/guardian's ability or resources needed to maintain the individual's living in the home, hospitalization/institutionalization etc), **and** 3. Individual, caregiver/responsible family members/legal guardian, or provider must exhaust all other possible resources for obtaining the needed goods/services—this service provides payment of last resort, **and** 4. Youth/family has not received this service for more than one other episode of need during the current fiscal year.
Continuing Stay Criteria	1. Youth must continue to meet Core Customer criteria for Ongoing services, and 2. Youth or the youth's caregiver/responsible family members/legal guardian must continue to be in need of the same specific good or service as when enrolled in Consumer/Family Assistance, that will directly improve functioning (e.g. directly lead to an increase in specific positive behaviors/skills/resources that will allow the youth to leave an institution and/or obtain more community-based living), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of caregiver's/family's/guardian's ability or resources needed to maintain the youth's living in the home/community), and 3. Youth, caregiver/ responsible family members/legal guardian, and provider must continue to lack any other possible resources for obtaining the needed goods/services.
Discharge Criteria	1. Youth no longer meets Core Customer criteria for Ongoing services, **or** 2. Youth or the youth's caregiver/responsible family

	members/legal guardian no longer continues to be in need of the good or service, **or** 3. Youth or the youth's caregiver/responsible family members/legal guardian has received the good in the allotted amount or service for the allotted timeframe as described below in "Additional Service Criteria" # 3, **or** 4. The youth or the youth's caregiver/responsible family members/legal guardian request discontinuance of the service.
Service Exclusions	Goods and services that are included as a part of other services the youth is enrolled in or could be enrolled in are excluded.
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. This service must not pay for the regular staffing of specific programs or services in the provider's agency.
2. Service may pay for a 1:1 mentor, behavioral aide, etc. for an individual youth, within the following limits:
   a. Other means are not available to pay for the mentor, behavioral aide etc., such as state funding, Medicaid, self-pay or private insurance.
   b. The mentor, behavioral aide, etc. cannot be used to supplement the staffing of any program or service in the provider agency.
   c. The mentor, behavioral aide, etc. cannot be used as a 1:1 staff for the youth during the times the youth is attending other programming/services offered by provider agency/ies.

C. Clinical Operations

1. This service must not pay for transportation to MH/DD/AD services.
2. This service must not pay for the operating, programmatic, or administrative expenses of any other program or service offered by the provider agency.
3. The youth/family cannot receive this service for more than two episodes of need per fiscal year.
4. Services obtained (e.g. a behavioral aide/mentor etc) are intended to be of short duration and must be provided through this service for no longer than 3 months, or until the direct consumer benefit is realized, whichever occurs sooner.
5. Each type of necessary good obtained through this service is intended to be of short duration and must be purchased for no longer/in no greater amount than is reasonably necessary to avoid/resolve the immediate crisis or achieve the targeted increase in functioning. Some items have specific limits that cannot be surpassed during a single episode of need. The least duration and/or amount necessary of such items should be provided. Up to:

- one month's rental/mortgage assistance;
- one month's assistance with utilities and/or other critical bills;
- one housing deposit;
- one month's supply of groceries (for the individual);
- one month of medications;
- one assistive device (unless a particular device is required in multiple according to commonly understood definition/practice such as a hearing aide for each ear, a one month supply of diabetic supplies etc);
- one to two weeks' worth of clothing.

Similar guidelines should be used with other items not on this list.

6. In general, the maximum yearly monetary limit for this service is $2000 per youth/family per fiscal year. Individuals leaving an institution after a stay of at least 60 days who have had their benefits suspended or who do not yet have income or other benefits established may need greater assistance than the allowances indicated above for rent, bills, groceries and other items/services. For such children/families, multiple months of rent, bills, groceries, services, etc. may be purchased, at a maximum yearly monetary limit of $5000 per youth per fiscal year.
7. The youth's caregiver/responsible family members/legal guardian is/are eligible only if the youth is residing in the same residence, or if funds would be used to prepare the home and caregiver/responsible family members/legal guardian for the return of the individual to the home from an alternative out-of-home living arrangement. Eligibility for the Consumer/Family Assistance service does not equate to an entitlement to the service. Prioritizing eligible individuals and/or their caregivers/responsible family members/legal guardians to receive services is the responsibility of the service provider. A standard protocol must be utilized by the service provider to assess and approve the youth and/or the youth's caregiver's/responsible family members'/legal guardian's needs in regard to 1) the criticalness of the need(s) in direct relation to the youth's functioning and ability to return to/remain in the community, and 2) the youth's and/or caregiver's/responsible family's/legal guardian's or provider's ability to obtain the needed goods or services through other viable means.

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service.

F. Reporting Requirements

1. The agency must submit a monthly report (and upon request at anytime) to the DMHDDAD on expenditures in a specified format.
2. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Documentation that authorized goods/services are not available through other viable means must be made in the youth's chart.
2. Details regarding the goods/services procured, associated costs, and resulting benefit to the youth must be documented in the clinical record.

Crisis Stabilization Program Services					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem	H0018	HA	U2		

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

1) Psychiatric medical assessment;
2) Crisis assessment, support and intervention;
3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
4) Medication administration, management and monitoring;
5) Brief individual, group and/or family counseling; and
6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the Division of MHDDAD as an emergency receiving and evaluation facility

Target Population	Children and Adolescents experiencing: Severe situational crisis SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-Occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential
Unit Value	Unit=1 day
Reimbursement Rate	$209.22/unit
Initial Authorization	20 days
Re-Authorization	
Authorization Period	20 days
UAS: **Budget and Expense Categories**	Crisis Services Provider 234 – C&A Mental Health 834 – C&A Addictive Diseases

Admission Criteria	1. Treatment at a lower level of care has been attempted or given serious consideration; **and #2 and/or #3 are met**: 2. Child/Youth has a known or suspected illness/disorder in keeping with target populations listed above; **or** 3. Child/Youth is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; **and one or more of the following**: 4. Child/Youth presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; **or** 5. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; **or** 6. Child/youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; **or** 7. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	1. Child/youth no longer meets admission guidelines requirements; **or** 2. Crisis situation is resolved and an adequate continuing care plan has been established; **or** 3. Child/youth does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following: Diagnosis/Functional Assessment, Community Support- Individual or Community Support- Team as part of a transition to these less intensive services.
Clinical Exclusions	1. Youth is not in crisis. 2. Youth does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.

Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Programs (CSP) providing medically monitored short-term residential psychiatric stabilization and detoxification services, shall be designated by the Department as both an emergency receiving facility and an

evaluation facility and must be surveyed and certified by the Division of MHDDAD.

2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders* "Core Requirements for All Providers" and DMHDDAD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. Maximum stay in a crisis bed is 14 days (excluding Saturdays, Sundays and holidays) for children and adolescents (a child/adolescent occupying a transitional bed may remain in the CSP for additional calendar days (not to exceed total of 29 calendar days in the CSP) if the date of transfer and length of stay in the transitional bed is documented).
4. Youth occupying transitional beds must receive services from outside the CSP (i.e. community-based services) on a daily basis.
5. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
6. A CSP must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSP and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring the youth to a designated treatment facility when the CPS is unable to stabilize the youth.

B. Staffing Requirements

1. A physician or a staff member under the supervision of a physician, practicing within the scope of State law, must provide Crisis Stabilization Program (CSP) Services.
2. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
3. A CSP must employ a fulltime Nursing Administrator who is a Registered Nurse.
4. A CSP must have a Registered Nurse present at the facility at all times.
5. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
6. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. A physician must evaluate a child/youth referred to a CSP within 24 hours of the referral.

2. A CSP must follow the seclusion and restraint procedures included in the Division's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."
3. For youth with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Youth served in transitional beds may access an array of community-based services in preparation for their transition out of the CSP, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Crisis Stabilization Programs are billed as "Crisis Residential" for Medicaid recipients.
2. For those CSPs that bill Medicaid, Crisis Residential Services are limited to 16 beds.
3. Beds designated as transitional beds are not billed as "Crisis Residential" but are billed under the service Residential Rehabilitative Supports II.

F. Reporting Requirements

1. Providers must designate either CSP bed use or transitional bed use in MICP submissions.
2. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In order to bill for the per diem rate, the consumer must have participated in the program for a minimum of 8 hours in the identified 12:00AM to 11:59PM day.
2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
3. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

Intensive Family Intervention					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community-Based Wrap-Around Services; Per 15 minutes	H2021				

Definition of Service: A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic foster care, therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Diffuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensure linkage to needed community services and resources; and
- Improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive assessment and are directed towards the identified youth and his or her behavioral health needs and goals as identified in the Individualized Resiliency Plan.

Target Population	Children and Adolescents with SED and/or Substance Related Disorders
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP Part III
Utilization Criteria	Available to those with CAFAS scores: 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential (transition) 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Unit Value	Unit=15 minutes
Reimbursement Rate	$20.11/unit
Initial Authorization	576 units
Re-Authorization	576 units Continued Stay Review is required after 12 weeks.
Authorization Period	90 days
UAS: **Budget and Expense Categories**	Intensive Treatment Services Provider 253 – C&A Mental Health 853 – C&A Addictive Diseases

Admission Criteria	1. Youth has a diagnosis and duration of symptoms which classify the illness as SED and/or is diagnosed Substance Related Disorder; **and one or more of the following:** 2. Youth has received services through other services modalities and needs additional or different supports and/or structure. Treatment at a lower intensity has been attempted or given serious consideration; **or** 3. Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; **or** 4. Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; **or** 5. Because of behavioral health issues, the youth is at immediate risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent; **or** 6. Because of behavioral health issues, the youth is at immediate risk of legal system intervention or is currently involved with DJJ.
Continuing Stay Criteria	1. Same as above.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Youth no longer meets the admission criteria; **or** 3. Goals of the Individualized Resiliency Plan have been substantially met; **or** 4. Individual and family request discharge, and the individual is not imminently dangerous; **or** 5. Transfer to another service is warranted by change in the individual's condition; **or** 6. Individual requires services not available within this service.
Service Exclusions	Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, Community Support Team, and/or Crisis Residential.
Clinical Exclusions	1. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury 2. Youth can effectively and safely be treated at a lower intensity of service.

Additional Service Criteria:

A. Required Components:

1. The organization has established procedures/protocols for handling emergency and crisis situations that describe methods for intervention with youth who require psychiatric hospitalization.
2. Each IFI provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:
    - Particular family preservation, resource coordination, crisis intervention and wraparound service models utilized (MST, MDFT, etc), types of intervention practiced, and typical daily schedule for staff,
    - Staffing pattern in accordance with this definition and how staff is deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated,
    - Hours of operation, the staff assigned, and types of services provided to consumers, families, parents, and/or guardians,
    - How the plan for services is modified or adjusted to meet the needs specified in each Individualized Resiliency Plan, and
    - Description of how the team works with the family and other agencies/support systems to build a clinically oriented transition and discharge plan.
4. At least 60% of services must be provided face-to-face with children and their families, and 80% of all face-to-face services must be delivered in non-clinic settings over the authorization period.
5. At least 50% of IFI face-to-face contacts must include the child (identified consumer). However, when the child is not included in the face-to-face contacts, the focus of the contacts must remain on the child and their goals as identified on their IRP.

B. Staffing Requirements:

1. Intensive Family Intervention is provided by a team consisting of the family and the following practitioners:
    - One fulltime Team Leader who is licensed (and/or certified as a CAC II if the target population is solely diagnosed with substance related disorders) by the State of Georgia under the Practice Acts and has at least 3 years of experience working with children with serious emotional disturbances. LAMFT, LMSW, LAPC staff do not qualify for this position. Team leaders who are employed February 2005 in this position and have an associate license may remain in this position if they are in active pursuit of the full clinical licensure. In this instance, team leaders must be licensed by July 2007. The team leader must be actively engaged in the provision of the IFI service.
    - Two to three fulltime equivalent paraprofessionals who work under the supervision of the Team Leader.

- The team may also include an additional Mental Health Professional or Substance Abuse Professional.

2. For those families who require it, the Intensive Family Intervention Team must have access to psychiatric and psychological services, as provided by a Psychiatrist or a Licensed Psychologist.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice components/models are multisystemic therapy, multidimensional family therapy, and others as appropriate to the child, family and issues to be addressed.
4. The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessional, and 16 families for teams with three paraprofessionals (which is the upper limit) at any given time. The staff-to-family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.
5. Documentation must demonstrate that at least 2 team members are actively engaged in the support of each consumer served by the team. One of these team members must be appropriately licensed/credentialed (CACII) to provide any professional counseling and treatment modalities/interventions needed by the consumer and must provide these modalities/interventions as clinically appropriate according to the needs of the consumer.

C. Clinical Operations:

1. In-home services include consultation with the individual, parents, or other caregivers regarding medications, behavior management skills, and dealing with the responses of the individual, other caregivers and family members, and coordinating with other child-serving treatment providers.
2. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual or family develops strengths and coping skills.
3. Intensive Family Intervention must be provided through a team approach (as evidenced in documentation) and flexible services designed to address concrete therapeutic and environmental issues in order to stabilize a situation quickly. Services are family focused, active and rehabilitative, and delivered primarily in the home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individual's functioning.
4. Service delivery must be preceded by a thorough assessment of the child and the family in order to develop an appropriate and effective treatment plan.
5. IFI services provided to children and youth must be coordinated with the family and significant others and with other systems of care such as the school system, the juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
6. IFI providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive, and foster), schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that youth/families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. parents' place of employment or school), especially if

staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of youth's privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with a youth during their school time, mutually agree upon a meeting time during the day that is the least conspicuous from the youth's point of view).

7. The organization must have policies that govern the provision of services in natural settings and can document that it respects the youth's and/or family's right to privacy and confidentiality when services are provided in these settings
8. When a projected discharge date for the service has been set, the youth may begin to receive Community Support Team services two weeks prior to IFI discharge for continuity of care purposes only.

D. Service Accessibility:

1. Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention.
2. Due to the intensity of the service providers must offer a minimum of 3 contacts per week with the youth/family.

E. Additional Medical Requirements:

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Outdoor Therapeutic Program					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
		[redacted]	[redacted]	[redacted]	[redacted]

Definition of Service: The Outdoor Therapeutic Program is a wilderness residential treatment program for troubled youth. The mission of the OTP is to operate a program that promotes growth through challenge, education, positive reinforcement and nurturing to youth and families who are deemed most in need and likely to benefit.

Placement in this program is appropriate for youth who have social, emotional behavioral and/or mental health disorders such as depression, ADHD, oppositional defiant disorders, and substance use/abuse. Many of the youth have poor school performance, family problems, and peer relationship problems. All youth enrolled in the program are assessed by gathering information from the referral sources (sponsors) and parents or legal guardians. From the assessment process, an individualized treatment plan is developed with the youth, parents and referral "sponsor" to guide the youth's treatment. The newly admitted youth join an existing group of peers and counselors living in a wilderness setting. Each group is an autonomous community with campers learning to accept and share responsibility for basic living requirements. Skills in teamwork, compromise and leadership emerge and develop, as campers must learn to cooperate in order for the camp community to function. The counselors provide guidance and suggestions, but the group members are responsible for planning and accomplishing the required chores and for maintaining group cohesiveness.

Target Population	Children and Adolescents with SED and/or Substance Related Disorders
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP Part III
Utilization Criteria	Available to those with CAFAS scores: 10-50: Resiliency Maintenance (for community reintegration only) 60-90: Low Intensity Community-Based Services (for community reintegration only) 140-180: Medically Monitored Community Residential
Unit Value	Unit=1 day
Reimbursement Rate	[redacted]
Initial Authorization	90 days
Re-Authorization	90 days
Authorization Period	90 days
UAS: Budget and Expense Categories	

Admission Criteria	1. Youth meet the target population; and 2. Youth has a severe emotional, behavioral and/or mental health disorder such as depression and substance use/abuse; and 3. Youth has poor school performance, family problems, and/or peer relationship problems; and 4. CAFAS scores indicate the need for residential treatment; and 5. Youth has exhausted other less restrictive, community based options as demonstrated by documentation from multiple community resources; and 6. At least one family member or caregiver agrees to participate in the program and can provide sufficient supports to keep the C&A safe in the home and community; and 7. Level of functioning precludes provision of services in less restrictive services
Continuing Stay Criteria	1. Youth has behavior that continues to create a risk for more restrictive placement despite treatment efforts and the C&A and family needs more time in this treatment program to acquire social, functional and medical management skills needed to successfully function in the community. 2. Continued presence of presenting problems associated with placement. 3. Continuing stay criteria will be reviewed every 90 days. The maximum length of stay shall be 10 months. If the program is not successful within this designated amount of time, other intensive support options should be tried as clinical alternatives.
Discharge Criteria	1. No longer meets admission criteria 2. Goals for appropriate individualized resiliency plan have been met. 3. Adequate continuing resiliency and aftercare plan have been established 4. Family/guardian requests discharge 5. Youth requires treatment services not available through this service
Service Exclusions	Community Inpatient Services, IFI
Clinical Exclusions	1. Presence of any behaviors that require a more intensive level of service due to dangerousness to self or others 2. Refuses to participate in program activities.

Additional Service Criteria:

A. Required Components

1. The Outdoor Therapeutic Camps are state-operated and administered by the DMHDDAD.
2. The newly admitted youth join an existing group of peers and counselors living in a wilderness setting. Each group is an autonomous community with campers learning to accept and share responsibility for basic living requirements.

3. Each camp has the capacity for 40-44 youth, ranging in age from age 12-17.
4. All campers return home for six days each month to visit with their families, see their family physician and/or psychiatrist if necessary, and see an individual and/or family therapist in their home community.
5. Youth typically stay in the program between 7 and 12 months, with an average length of stay of 10 months.
6. Linkages with other child-serving agencies and community supports should be clearly described within the comprehensive program descriptions.
7. There is a fully accredited school program at each camp, which are regularly monitored by the Department of Education. School attendance is required for each group and each camper is expected to demonstrate effort toward improving school behavior and school skills. Instruction is based on the Georgia Core Curriculum and the assessed achievement level of each camper. Teachers are certified in a core subject area, as well as Behavior Disorder (BD) specialty certifications.
8. There will be offered 20 hours per week for school/vocational assignments.
9. There will be daily goal setting and group meetings.
10. There will be 3 meals, 1 snack, and recreation time each day.

B. Staffing Requirements

1. Two counselors are with each group of ten to eleven campers around the clock to monitor and supervise youth, as well as to provide counseling and support whenever needed.
2. Outdoor Therapeutic Camps each have four groups of ten to eleven campers. The staff to youth ratio for each group must be no less than 2:11.
3. A Camp Director who has a minimum of a bachelor's degree and experience supervising groups must supervise services.
4. The program will have one registered nurse available at each site that provides nursing assessment, and medication monitoring of administration under physicians orders.
5. All direct care staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to identify situations that require additional interventions.
6. The camp must have an educational supervisor and teachers to meet the educational needs of the campers.
7. The camp must have social service providers who develop resiliency plans and communicate with the families.
8. The program will contract with a Psychiatrist at each site to meet with campers and review the resiliency plan.
9. Services must have nursing staff and clinical staff who have proficiency in working with the target population and with families as partners. They must have training and demonstrate proficiency in cultural competence as related to youth and families who are culturally different from them.
10. Staff must be trained in evidenced based practices specific to brief therapeutic interventions with youth/families who are experiencing a severe emotional disturbance.

C. Clinical Operations

1. Skills in teamwork, compromise and leadership emerge and develop, as campers must learn to cooperate in order for the camp community to function. The counselors provide guidance and suggestions, but the group members are responsible for planning and accomplishing the required chores and for maintaining group cohesiveness.
2. The most effective counseling is provided in sessions called "groups" that are called by individual campers or counselors at any time a camper's behavior or attitude is having a negative impact on the group and its goals. Campers also call "groups" to express and share feelings with other campers and to resolve conflicts.
3. Families participate in monthly group therapy at camp and have opportunities to learn new parenting skills while their child is at camp.
4. Services must operate in accordance with all identified safety and health standards.
5. Services must evidence strength-based, family-driven and youth guided approaches, and evidenced based practices.
6. Discharge planning is conducted monthly and is addressed through daily monitoring of the treatment progress.

D. Service Access

1. Referrals are made through local multi-agency teams for children, made up of professionals from child-serving agencies such as mental health, child welfare, education and juvenile justice representatives in the local communities. The referrals are made to the OTP's only after other less restrictive, community-based options have been tried and exhausted.
2. Services are available 24/7, which include monthly home visits.

E. Reporting Requirements

1. Youth enrolled in this service are reported through MICP enrollment and reporting mechanisms.

F. Documentation Requirements

1. Documentation must reflect the activities that the youth and families participate in by date, time, and duration. Weekly documentation must indicate counselor's notes on each individual treatment objective. Weekly group notes must be individualized and placed in each youth's medical record. Weekly documentation must reflect progress towards the resolution of presenting problems, and progress towards being fully re-integrated into school and community activities.
2. Quarterly documentation must address discharge planning progress and coordination with other agencies and the family towards this end.
3. Psychiatric Assessments, medication orders, and nursing notes must be documented according to DMHDDAD policy and procedures regarding Medical Records.

Rehabilitative Supports for Individuals in Residential Alternatives Levels 1 & 2

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing, Per Diem	H0043	U1			
Supported Housing, Per Diem	H0043	U2			

Definition of Service: Residential Rehabilitative Supports are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; and to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders. This service provides support and assistance to the youth and the family to identify, adjust, and manage symptoms; enhance participation in group living and community activities; and, develop positive personal and interpersonal skills and behaviors to meet the youth's developmental needs as impacted by his/her behavioral health issues.

Services are delivered to youth according to their specific needs. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.

Rehabilitative services must be provided in a licensed residential setting (see A.2.) with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. All facilities providing residential rehabilitative supports must be staffed 24 hours a day, 7 days a week.

Target Population	Children and Adolescents with Severe Emotional Disturbance, Children, Adolescents and Adults with Substance Abuse Issues, Children, Adolescents and Adults with Co-Occurring Substance Abuse and Mental Illness Children, Adolescents and Adults with Co-Occurring Mental Illnesses and MR/DD. Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and MR/DD.
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP Part III.

Utilization Criteria	<u>Available to those with CAFAS scores:</u> 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential	
Unit Value	Unit=1 day	
Reimbursement Rate	H0043U1	$31.34
	H0043U2	$38.58
Initial Authorization	180 days	
Re-Authorization	180 days	
Authorization Period	180 days	
UAS: **Budget and Expense Categories**	<u>Residential Services Provider</u> Residential Alternatives I 242 – C&A Mental Health 842 – C&A Addictive Diseases Residential Alternatives II 243 – C&A Mental Health 843 – C&A Addictive Diseases	
Admission Criteria	1. Youth must have symptoms of a SED or a substance related disorder; **and one or more of the following:** 2. Youth's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Youth/family has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Youth has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the youth's needs; **or** 5. Youth has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.	
Continuing Stay Criteria	Youth continues to meet Admissions Criteria.	
Discharge Criteria	1. Youth/family requests discharge; **or** 2. Youth has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in youth's condition	
Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Program. Residential Rehabilitative Supports 1 and 2 cannot be billed simultaneously.	

Clinical Exclusions	1. Severity of identified youth issues precludes provision of services in this service 2. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Youth can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components:

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to youth with SED and/or substance abuse diagnosis. If the agency does not have a license/letter from ORS related to operations, there must be enough administrative documentation to support the non-applicability of ORS license.
3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week.
4. Level I Residential Rehabilitation Services must provide 4 hours per week of structured programming and/or services.
5. Level II Residential Rehabilitation Services must provide 6 hours per week of structured programming and/or services.

B. Staffing Requirements:

1. A Mental Health Professional or SAM, or a paraprofessional under the supervision of a Mental Health Professional or SAM must provide all Residential Rehabilitation Services.
2. If applicable, facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Office of Regulatory Services (see A.2).
3. A Mental Health Professional or SAM must supervise all Residential Support Services.
4. The organization that provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff in accordance with ORS/accreditation/certification.
5. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the Residential Rehabilitation services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and expected outcomes.
2. Residential Rehabilitation Services assist youth in developing daily living skills that enable them to manage the symptoms and behaviors linked to their psychiatric or addictive disorder. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward developing skills in functional areas that interfere with the youth's ability to participate in the community, retain school tenure, develop or maintain social relationships, or age-appropriately participate in social, interpersonal, or community activities.
3. Residential Rehabilitation Services must include symptom management or supportive counseling; behavioral management; medication education, training and support; support, supervision, and problem solving skill development; development of community living skills that serve to promote age-appropriate utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate age-appropriate interpersonal behavior.

D. Service Access

E. Additional Medicaid Requirements

1. This is a Medicaid-billable service and is subject to all Medicaid policies, procedures, and rules.
2. Any facility billing Medicaid for this service may not exceed 16 beds.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. The organization must develop and maintain sufficient written documentation to support the Residential Rehabilitation Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Rehabilitation Service on the date of service. The youth's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.
2. Weekly progress notes must be entered in the youth's record to enable the monitoring of the youth's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.

3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Residential Rehabilitation Services may only be provided in facilities that have no more than 16 beds.
2. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
3. Each residential facility must comply with all relevant fire safety codes.
4. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
5. The organization must comply with the American with Disabilities Act.
6. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted.
7. Evacuation routes must be clearly marked by exit signs.
8. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Respite					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Respite Care Services, Not in the Home, Per Diem	H0045				
Unskilled Respite Care, Not Hospice, Per Diem	S5151				

Definition of Service: Respite services are brief periods of support or relief for family/ responsible caregiver(s) of individuals with mental illnesses and/or substance related disorders. Respite is provided: (1) when the youth is experiencing a psychiatric, substance related or behavioral crisis and needs structured, short-term support; (2) when families/responsible caregiver(s) are in need of additional support or relief; or (3) when the youth and family/responsible caregiver(s) experience the need for therapeutic relief from the stresses of their mutual cohabitation. Respite may be provided in-home (i.e. provider delivers service in youth's home) or out-of-home (youth receives service outside of their home), and may include day activities as well as overnight activities/accommodations as appropriate to the situation.

Target Population	Children and Adolescents experiencing: SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services
Unit Value	Unit=1 day
Reimbursement Rate	$56.00
Initial Authorization	While the actual respite should be very short-term in nature, this service can be authorized as part of a 180 day Recovery plan. There are 30 days maximum that can be accessed per authorization request.
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Consumer/Family Support Services Provider 236– C&A Mental Health 836 – C&A Addictive Diseases

Admission Criteria	1. Youth meets target population as identified above; **and** 2. Youth has a need for short-term support which could delay or prevent the need for out-of-home placement or higher levels of service intensity (such as acute hospitalization); **and one or more of the following:** 3. Youth has a circumstance which destabilizes his/her current living arrangement and the provision of this service would provide short-term relief and support of the youth; **or** 4. The family has an immediate need for support and relief from the responsibility and stress of managing behavioral health issues; **or** 5. The family has an immediate need to participate in an emergency event during which lack of supervision may cause the youth a setback in his/her Resiliency plan.
Continuing Stay Criteria	1. Youth continues to meet admission criteria as defined above; **and** 2. Youth has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs.
Discharge Criteria	1. Family requests discharge; or 2. Youth/family have acquired natural supports that supplant the need for this service.
Service Exclusions	Traditional 24/7 Residential Supports I and II (Service may be provided in addition to Therapeutic Foster Care on a limited basis to preserve placement).
Clinical Exclusions	1. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury. 2. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services).

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

C. Clinical Operations

D. Service Access

1. A limit of 30 day may be used within a single authorization period.

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid-billable service.

F. Reporting Requirements

1. All other applicable MICP and DMHDDAD reporting requirements must be adhered to.

Room & Board

Definition of Service: Effective October 1, 2006, this is a state-funded rental subsidy for consumers in community residential services which must be justified by a personal consumer budget.

Target Population	Non-SSI Recipients who are Children and Adolescents experiencing: SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP Part III.
Utilization Criteria	Available to those with CAFAS scores: 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	Unit=1 day
Reimbursement Rate	$13.15/day maximum that DMHDDAD will pay
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Residential Services Provider 248– C&A Mental Health 848 – C&A Addictive Diseases
Admission Criteria	1. Youth meets target population as identified above; **and** 2. Based upon a personal budget, youth has a need for financial support for a living arrangement.
Continuing Stay Criteria	1. Youth continues to meet admission criteria as defined above; **and** 2. Youth has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs.
Discharge Criteria	1. Family requests discharge; or 2. Youth/family have acquired natural supports that supplant the need for this service.
Service Exclusions	Crisis Residential Services
Clinical Exclusions	Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury.

Therapeutic Foster Care					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Foster Care, Therapeutic, Child, Per Diem	S5145				

Definition of Service: Twenty-four-hour specialized living arrangements for children unable to live with their parents/responsible caregiver(s). Services provide a family living environment with foster families specifically recruited and trained in approaches and techniques on working effectively with this population. When children and adolescents are living in a Therapeutic Foster Home, therapeutic foster parents are considered part of the treatment team and help develop and implement specific treatment plans for the individual. Each therapeutic foster care home has no more than a maximum of two children except in unusual circumstances such as sibling group, as long as clinically appropriate. Therapeutic foster care home providers may not serve other individuals under other types of service. A minimum of one licensed staff person supports every six homes and has their training and consultations duties outlined.

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports should be cross-referenced for any associated rules and requirements.

Target Population	Children and Adolescents with SED Children and Adolescents with Co-Occurring SED and Substance Related Disorders
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part III
Utilization Criteria	Available to those with CAFAS scores: 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential
Unit Value	Unit=1 day (per diem)
Reimbursement Rate	$38.58
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Residential Services Provider 246 – C&A Mental Health 846 – C&A Addictive Diseases

Admission Criteria	1. Youth must have symptoms of a SED or a substance related disorder; **and one or more of the following:** 2. Youth's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Youth/family have insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Youth has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the youth's needs; **or** 5. Youth has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Youth continues to meet Admissions Criteria.
Discharge Criteria	1. Youth/family requests discharge; or 2. Youth has acquired rehabilitative skills to independently manage his/her own housing; or 3. Transfer to another service is warranted by change in youth's condition
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.
Clinical Exclusions	1. Severity of identified youth issues precludes provision of services in this service. 2. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Youth can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to youth with SED and/or substance related diagnoses.
2. An agency that provides financial assistance that enables a consumer to access housing supports must adequately document all financial transactions that allow the DMHDDAD to maintain accountability of funds distribution. Detailed documentation of expenditures will be required of providers during the FY06 contract year.

3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers, must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of youth and their families.
2. A Mental Health Professional or a SAM must supervise all Residential Support Services.
3. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
    a. Evidence of licensure, certification or registration as applicable and as required by the job being performed
    b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
    c. Appropriate references and background check
    d. A process by which all staff, as a condition of hiring, must:
        i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
        ii. Indicate if they are presently using illegal drugs
        iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.
4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services should be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required services.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility/home must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility/home must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. If service is delivered in a home, evacuation routes must be identified in agency home management plan.
6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Substance Abuse Adolescent Day Treatment					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Day Treatment; Per Hour	H2012	HA	HF		

Definition of Service: Specialized after-school and weekend group-based services including counseling (individual, group, family), parent/consumer education, skill and socialization training which focus on the amelioration of functional and behavioral deficits resulting from a substance related disorder. Services are to be available at least 5 days per week to allow youth's access to supports and treatment deemed necessary to build the youth's age-appropriate functioning within the community and family. Intense coordination/linkage with schools and other child serving agencies is mandatory. This service promotes resiliency and recovery from substance use disorders incorporating the basic tenets of clinical practice. This service is offered for a minimum of 2 hours per day and a maximum of 5 hours per day.

The programmatic goals of the service must be clearly articulated by the provider, utilizing population and issue-specific best/evidence based practices for service delivery and support. Some examples of best/evidence based practice models/components are Motivational Interviewing/Enhancement, Behavioral Family Therapy, Functional Family Therapy, Brief Strategic Family Therapy, Cognitive Behavioral Therapy, Seven Challenges and others as appropriate to the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices in adolescent substance abuse treatment. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical services provided by a multidisciplinary team, and are directed towards the identified youth and his or her behavioral health needs based upon the Individualized Resiliency Plan.

Target Population	Adolescents with Substance Related Disorders Adolescents with primary Substance Related Disorders and Co-Occurring SED
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part III
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential (transition) 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Unit Value	Unit=1 hour
Reimbursement Rate	$33.50/unit
Initial Authorization	450 units (unit = 1 hour)
Re-Authorization	450 units (unit = 1 hour)
Authorization Period	90 days
UAS: **Budget and Expense Categories**	C&A Day Services Provider 856 – C&A Addictive Diseases

Admission Criteria	1. Youth meets the diagnostic criteria for Substance-Related Disorder as defined by the current DSM or other standardized and widely accepted criteria; **and** 2. Youth meets the age criteria for adolescent treatment; **and** 3. Youth's biomedical conditions and problems, if any, are stable or are being concurrently addressed; **and one or more of the following:** a. Youth is currently unable to maintain behavioral stability for more than a 72-hour period, as evidenced by distractibility, negative emotions, or generalized anxiety; **or** b. Youth has a diagnosed emotional/behavioral disorder that requires monitoring and/or management due to a history indicating a high potential for distracting the individual from recovery **or** treatment; **or** c. There is a likelihood of drinking or drug use without close monitoring and structured support. *See also ASAM Level II treatment criteria.*
Continuing Stay Criteria	1. Youth continues to meet admission criteria 1, 2, and 3; and 2. Youth is responding to treatment as evidenced in progress toward goals, but has not yet met the full expectation of the objectives; **or** 3. Youth is beginning to recognize and understand his/her responsibility for addressing his/her illness, but still requires services and strategies to sustain personal responsibility and progress in treatment; **or** 4. Youth recognizes and understands relapse triggers, but has not developed sufficient coping skills to interrupt or postpone gratification or to change related inadequate impulse-control behaviors; **or** 5. Youth's substance-seeking behaviors, while diminishing, have not been reduced sufficiently to support functioning outside of a structured treatment environment. *See also ASAM Level II continued service criteria.*
Discharge Criteria	1. Adequate continuing care plan has been established; **and one or more of the following**: 2. Youth exhibits symptoms of acute intoxication and/or withdrawal and requires treatment at a more intensive level of service; **or** 3. Youth's problems have diminished in such a way that they can be managed through less intensive services; **or** 4. Youth has a confounding medical/behavioral issue interfering with addiction treatment; **or** 5. Youth recognizes the severity of his/her alcohol and other drug problem and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports or by continuing treatment in a less intensive level of care; **or**

	6. Youth has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continued alcohol/drug use to such an extent that no further progress is likely to occur. *See also ASAM Level II discharge criteria.*
Service Exclusions	Not offered at the same time as C&A Mental Health Day Treatment. Activity Therapy may not be offered as a discrete billable service, but may be included within this service package.
Clinical Exclusions	1. Youth manifests overt physiological withdrawal symptoms; **or** 2. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components:

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. The service is offered at an established clinic site.
3. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space.

B. Staffing Requirements

1. Maximum face-to-face ratio cannot be more than 10 youth to 1 direct service staff based on average daily attendance.
2. The program must be under the supervision of a Substance Abuse Manager.
3. The staff consists of at least 50% Substance Abuse Professionals.
4. Staff must have the knowledge of the developmental needs of youth and the program must be geared toward their interests and needs.
5. While MHP staff are not required for this service, the agency offering services to children and adolescents with co-occurring MH/AD issues must document that at least one staff has received 4 hours of co-occurring competency training within the last 2 years. This documentation shall be maintained in staff personnel records.

C. Clinical Operations

1. The program includes the availability of the following activities/training based on the youth's need and the targeted goals for treatment:

- Age-appropriate individual education regarding substance abuse and addiction, the recovery process and relapse prevention
- Introduction to the use of self-help groups (AA, NA, etc.)
- Group and Individual counseling/training including groups for targeted clinical needs
- Leisure and social skills with emphasis on how to handle leisure time without drinking or using drugs
- Interpersonal skills building including family communications and developing relationships with healthy individuals
- Simulated community living skills

2. There is a planned program for families that includes education regarding the disease concept and the impact of addiction on the family, the recovery process and relapse prevention, and introduction to self-help groups. Family services address adolescent developmental issues, especially those that may impact recovery, and requirements for maintaining abstinence.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In addition to other reporting requirements, there is at minimum a weekly activity note that summarizes the individual's progress or lack of progress toward goals identified in the Individualized Resiliency Plan. Documentation of daily attendance is also required for billing purposes.

Mental Health and Addictive Disease Services

Adults' CORE Benefit Package

Community Support – Individual					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	H2015				
Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	H2015	UK			

Definition of Service: Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist an individual in gaining access to necessary services and in restoring him or herself to the best possible functional level with the greatest degree of life quality enhancement, self-efficacy and recovery, illness self-management, and symptom reduction possible. The service activities of Community Support include:

- Assistance to the individual in the development and coordination of the Individual Recovery Plan (IRP);
- Support and intervention in crisis situations;
- Assistance to the individual in the development of advanced directives related to his/her behavioral healthcare; and
- Individualized interventions, which shall have as objectives:
  1) Identification, with individual, of strengths which may aid the individual in recovery, as well as barriers that impede the development of skills necessary for independent functioning in the community;
  2) Support to facilitate recovery (including support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
  3) For those who have achieved a level of recovery stability, support to maintain recovery;
  4) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, work, and other healthy social environments);
  5) Encouraging the development and eventual succession of natural supports in home, workplace and other environments;
  6) Assistance in the acquisition of symptom monitoring skills, illness self-management skills, and wellness skills and habits (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living;
  7) Assistance with financial management skill development;
  8) Assistance with personal development and work performance;
  9) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the individual's disability;
  10) Service and resource coordination to assist the individual in learning how to gain access to necessary rehabilitative, medical and other services;
  11) Assistance to individuals with illness self-management and wellness promotion as it relates to maintaining employment and other community tenure; and

12) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.
13) Identification, with individual, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

When the service is provided by a Certified Peer Specialist, the above functions/interventions should be performed with a special emphasis on recovery values and processes such as:

1) Empowering the individual to have hope for and participate in his or her own recovery;
2) Helping the individual identify personal motivations, strengths and needs related to attainment of independence in terms of skills, resources, and supports, and to use available strengths, resources and supports to achieve independence;
3) Helping the individual in the process of goal discovery and exploration to subsequently identify and achieve their personalized recovery goals (which should include attainment of meaningful employment if desired by the individual); and
4) Promoting an individual's responsibility related to illness self-management and wellness concepts.

This service is provided to individuals to maintain stability, independence and wellness in their daily community living. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased work tenure. Supports based on the individual's needs and satisfaction are used to sustain recovery from the effects of mental illness and substance abuse and to increase independent daily functioning and wellness. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to the community; general entitlements; mental health wellness activities, and psychiatric, addiction, medical services, crisis prevention and intervention services.

Target Population	Adults with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis, Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/ Developmental Disabilities

Benefit Information	*July 1, 2006-December 31, 2006:* Available to Core Customers for Brief Intervention and Stabilization (if the MICP was submitted prior to June 30, 2006). Also available to Core Customers in need of Ongoing Services and in this instance requires a MICP Part I and/or MICP Part II *January 1, 2007-June 30, 2007*: Available to Core Customers in need of Ongoing Services. Requires a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	$16.69/unit
Initial Authorization	600 units
Re-Authorization	600 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Adult Core Services Provider 126 – Adult Mental Health 726 – Adult Addictive Diseases
Admission Criteria	1. Individual must meet target population criteria as indicated above; **and one or more of the following:** 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; **or** 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Recovery Plan.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of Individualized Recovery Plan have been substantially met; **or** 3. Individual requests discharge and the individual is not imminently in danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in the individual's condition.
Service Exclusions	ACT

Clinical Exclusions	1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: • mental retardation • autism • organic mental disorder, or • Traumatic brain injury

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
    - Symptom self-monitoring and self-management of symptoms
    - Strategies and supportive interventions for avoiding out-of-community treatment for adults and building stronger knowledge of the adult's strengths and limitations
    - Relapse prevention strategies and plans
2. Community Support Services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and recovery goals.
3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
4. Individuals receiving Community Support Services must be seen face-to-face a minimum of once every 30 days. Individuals must also receive a telephone check in call once a month unless there have been 2 or more face-to-face contacts within the community. At least 60% of community support services must be delivered face-to-face with consumers, and at least 80% of all face-to-face services must be must be delivered in non-clinic settings over the authorization period. For CSI delivered to consumers who are receiving medication management only, services are not counted in the minimum offsite service requirement. The Community Support - Individual provider, through documentation, must demonstrate that a significant effort has been made to make a face-to-face contact with the consumer outside the agency; however, when multiple attempts made to contact consumer have failed and have been documented, Community Support - Individual may still be billed.
5. When Community Support - Individual supports consumers participating in medication management as the primary focus of service, the following allowances apply:
    a. These consumers are not counted in the offsite service requirement or the consumer-to-staff ratio.
    b. These consumers are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
    c. These consumers who are struggling with goal accomplishment, have increased symptoms, increased resource needs, or increased risk due to poor natural supports should be reconsidered for traditional CSI or CST (see also item D.2.).

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
   - Mental Health Professional (MHP)
   - Substance Abuse Manager (SAM)
2. Under the supervision of a Physician, an MHP, or a SAM, the following staff may also provide Community Support:
   - Certified Peer Specialists
   - Paraprofessional staff
3. Community Support - Individual providers must maintain a recommended consumer-to-staff ratio of 30 consumers per staff member and a maximum ratio of 50 consumers per staff member. Individuals who receive only medication management are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support - Individual services may include (with the permission of the adult) coordination with family and significant others and with other systems/supports (e.g. work, religious entities, corrections, aging agencies, etc) when appropriate to treatment and recovery needs.
2. Community Support - Individual providers must have the ability to deliver services in various environments, such as homes, jails, homeless shelters, correction facilities, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the consumer wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
3. The organization must have policies that govern the provision of services in natural settings and can document that it respects individuals' rights to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting individuals who require psychiatric hospitalization.
5. Each Community Support - Individual provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and individuals are targeted for such efforts.
6. The organization must have a Community Support Organizational Plan that addresses the following:
   - description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff

- description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.
- description of the hours of operations as related to access and availability to the individuals served and
- description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan

D. Service Accessibility

1. Agencies that provide Community Support Services must regularly provide individuals with contact information for appropriate crisis intervention services (i.e. the after hours crisis services telephone number).
2. Consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the LOCUS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.6. are no longer applied.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. When a non-face-to-face contact is provided, the H2015UK reporting mechanism shall be utilized.
2. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Crisis Intervention					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Crisis Intervention Service; Per 15 Minutes	H2011	U1			
Crisis Intervention Service; Per 15 Minutes	H2011	U2			

Definition of Service: Services directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of community placement or hospitalization. Often, a crisis exists at such time as an individual consumer and his or her identified natural resources decide to seek help and/or the individual, identified natural resources, or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the individual consumer and the individual's family and/or significant other, as well as other service providers. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting (e.g. home, jail, hospital, clinic etc).

The current behavioral health care advanced directive, if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the individual's wishes/choices by following the plan/advanced directive as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Diagnostic Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of this service to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Adults with Mental Health issues and/or Substance Related Disorders Adults experiencing a severe situational crisis

Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Unit Value	Unit=15 minutes
Reimbursement Rate	H2011 U1 $23.96/unit H2011 U2 $27.00/unit
Initial Authorization	16 units
Re-Authorization	Any use beyond 16 units will not be denied but will trigger an immediate retrospective review.
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Adult Core Services Provider 121– Adult Mental Health 721 – Adult Addictive Diseases
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; **and #2 and/or #3 are met:** 2. Individual has a known or suspected mental health diagnosis or Substance Related Disorder; **or** 3. Individual is at risk of harm to self, others and/or property. Risk may range from mild to imminent; **and one or both of the following:** 4. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; **or** 5. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	The Crisis Service with the "U2" modifier may not be authorized or billed with ACT.
Clinical Exclusions	1. The individuals' presenting situation is not dangerous to self or others. 2. Severity of clinical issues precludes provision of services at this level of care.

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. A Mental Health Professional (MHP), Substance Abuse Professional (SAP), Substance Abuse Manager (SAM), or staff under the supervision of an MHP or SAM must furnish Service.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.

F. Reporting Requirements

1. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Diagnostic Assessment and Individualized Recovery/Resiliency Planning					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Mental Health Assessment, by Non-Physician	H0031				
Mental Health Service Plan Development by Non-Physician	H0032				
PSYCHOLOGICAL TESTING: Psychodynamic assessment of emotionality, intellectual abilities, personality and psychopathology; e.g., MMPI, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)	96101	AH			
PSYCHOLOGICAL TESTING: Psychodynamic assessment of emotionality, intellectual abilities, personality and psychopathology; e.g., MMPI, Rorschach, WAIS with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face	96102				

Definition of Service: Individuals access this service when it has been determined through an initial screening that the person has mental health or addictive disease needs. The initial Diagnostic Assessment and resulting Individualized Recovery Plan are required within the first 30 days of service, with ongoing Diagnostic Assessments and plans completed as demanded by individual consumer need and/or by service policy.

The Diagnostic Assessment and Individualized Recovery Planning process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective, and may also include consumer-identified family and/or significant others as well as collateral agencies/treatment providers (including Certified Peer Specialists who have been working with consumers on goal discovery)/relevant individuals.

The purpose of the Diagnostic Assessment process is to perform a formalized assessment in order to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to develop or review collateral assessment information. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

Information from the diagnostic assessment should ultimately be used to develop with the individual an Individualized Recovery Plan that supports recovery and that is based on goals identified by the individual. As indicated, medical, nursing, peer, vocational, nutritional, etc. staff should inform the assessment and resulting IRP.

The cornerstone component of the adult Diagnostic Assessment and resulting Individualized Recovery Plan (IRP) involves a discussion with the adult individual regarding what recovery means to him or her personally (e.g. getting/keeping a job, having more friends, improvement of behavioral health symptoms etc), and the development of goals (i.e. outcomes) and objectives that are defined by, and meaningful to the individual based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, the individual should be offered the opportunity to develop an individualized Advanced Directive for behavioral health care, with the individual guiding these processes through the free expression of his or her wishes and through his or her assessment of the components developed for the advanced directive as being realistic for him or her. The entire process should involve the individual as a full partner and should focus on service and recovery goals/outcomes as identified by the individual.	

Target Population	A known or suspected mental health diagnosis and/or Substance-Related Disorder.	
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Part I and possibly a MICP Part II.	
Practice Guidelines	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential	
Unit Value	H0031 and H0032	Unit=15 minutes
	96101 AH and 96102	Unit=1 hour
Reimbursement Rate	H0031 and H0032	$23.56
	96101 AH and 96102	$94.24
Initial Authorization	16 units	
Re-Authorization	16 units	
Authorization Period	180 days	
UAS: **Budget and Expense Categories**	Adult Core Services Provider 120 – Adult Mental Health 720 – Adult Addictive Diseases	
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; **and** 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery planning; **and** 3. Individual meets Core Customer eligibility.	
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.	
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.	
Service Exclusions	None	

Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. These services are performed by a Mental Health Professional, Substance Abuse Professional, Substance Abuse Manager, or Certified Addiction Counselor II.

C. Clinical Operations

1. The individual consumer and any other consumer-identified natural supports should actively participate in the assessment and planning processes.
2. The Individualized Recovery Plan should be directed by the individual's personal recovery goals as defined by the individual.
3. Advanced directive planning shall be directed by the individual served and their needs/wishes met to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the individual and that the individual is therefore not likely to follow through with.

D. Service Access

E. Additional Medicaid Requirements

1. These services are performed by a Mental Health Professional, Substance Abuse Professional, Substance Abuse Manager, or Certified Addiction Counselor II.
2. Nutritional Assessments that were billed to this service code prior to July 1, 2006 shall no longer be encompassed under this code. Please see the Nursing Assessment Code.

F. Reporting Requirements

1. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DMHDDAD.
2. In addition to the authorization and Individualized Recovery/Resiliency Plan produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart as a Comprehensive Assessment.

Family Training/Counseling					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Counseling and Therapy, Per 15 minutes	H0004	HS			
Behavioral Health Counseling and Therapy, Per 15 minutes	H0004	HR			
Family Psychotherapy w/o the patient present (appropriate license required)	90846				
Conjoint Family Psychotherapy with the Patient Present (appropriate license required)	90807				
Skills Training and Development, per 15 minutes	H2014	HR			
Skills Training and Development, per 15 minutes	H2014	HS			

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner (a licensed therapist may conduct both counseling and training types of services/activities). Services are directed toward achievement of specific goals defined by the individual consumer and targeted to the consumer-identified family and specified in the Individualized Recovery Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family training/counseling provides systematic interactions between the identified individual consumer, staff and the individual's identified family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific therapeutic interventions/activities to enhance family roles, relationships, communication and functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills;
6) family roles and relationships;
7) daily living skills;
8) resource access and management skills; and
9) the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Part I and

	possibly a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential
Initial Authorization	If a MICP Part I is submitted only-24 units If a MICP Part III is submitted with a Part I- 60 units
Reauthorization	60 units
Unit Value	15 minutes
Reimbursement Rate	$20.78
UAS: **Budget and Expense Categories**	Adult Core Services Provider 130 – Adult Mental Health 730 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; **and** 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery Plan have been substantially met; **or** 3. Individual requests discharge and individual is in imminent danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in individual's condition; **or** 5. Individual requires more intensive services.
Service Exclusions	ACT and Crisis Residential

Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Couple's counseling is included under this service code as long as the counseling is directed toward the identified consumer and his/her goal attainment as identified in the Individualized Recovery Plan.
3. The Individualized Recovery Plan for the individual includes goals and objectives specific to the consumer-identified family for whom the service is being provided.

B. Staffing Requirements

1. Family training is provided by or under the supervision of a Mental Health Professional or a Substance Abuse Manager. A Mental Health Professional or a Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services must provide family counseling.
2. Training and Counseling should be differentiated by practice and practitioner. When the aforementioned services are addressed through didactic training, structured practice, coaching techniques, etc., a practitioner may include those with licenses to provide counseling (O.C.G.A. Practice Acts) and other paraprofessionals (including Certified Peer Specialists). Only a licensed clinician may perform family counseling when the intervention includes techniques involving the principles, methods and procedures of counseling that assist the family in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

C. **Clinical Operations**

1. Modes of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

D. Service Access

1. Services may not exceed 8 Billable units in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

G. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Group Training/Counseling					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Counseling and Therapy, Per 15 Minutes	H0004	HQ			
Behavioral Health Counseling and Therapy, Per 15 Minutes	H0004	HQ	HR		
Behavioral Health Counseling and Therapy, Per 15 Minutes	H0004	HQ	HS		
Skills Training and Development, Per 15 Minutes	H2014	HQ			
Skills Training and Development, Per 15 Minutes	H2014	HQ	HR		
Skills Training and Development, Per 15 Minutes	H2014	HQ	HS		
Group Psychotherapy Other Than of a Multiple Family Group (appropriate license required)	90853				

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided in a group format by a qualified clinician or practitioner (a licensed therapist may conduct both counseling and training types of services/activities). Services are directed toward achievement of specific goals defined by the individual consumer and specified in the Individualized Recovery Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills;
6) daily living skills;
7) resource management skills;
8) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs; and
9) skills necessary to access community resources and support systems.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part II.

Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential
Initial Authorization	If a MICP Part I is submitted only-24 units If a MICP Part III is submitted with a Part I- 200 units
Re-Authorization	200 units
Authorization Period	180 days
Reimbursement Rate	$14.30
Unit Value	Unit=15 minutes
UAS: **Budget and Expense Categories**	Core Services Provider 129 – Adult Mental Health 729 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. The individual's recovery goal/s which are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery Plan have been substantially met; **or** 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; **or** 4. Transfer to another service/level of care is warranted by change in individual's condition; **or** 5. Individual requires more intensive services.
Service Exclusions	Crisis Residential See also below, Item A.2. and A.3.

Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Extended groups are not allowed under this service code. Any services in excess of 2 hours in a given day may be subject to scrutiny by the external review organization.
3. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day support/treatment activities.
4. When billed concurrently with ACT services, this service must focus on group counseling rather than training, and counseling must be curriculum based. Groups for ACT service recipients cannot include non-ACT service recipients.

B. Staffing Requirements

1. Training is provided by or under the supervision of a Mental Health Professional or a Substance Abuse Manager. A Mental Health Professional or a Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to Perform Counseling Services must provide group counseling. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance.
2. Training and Counseling should be differentiated by practice and practitioner. When the aforementioned services are addressed through didactic training, structured practice, coaching techniques, etc., a practitioner may include those with licenses to provide counseling (O.C.G.A. Practice Acts) and other paraprofessionals (including Certified Peer Specialists). Only a licensed clinician may perform group counseling when the

intervention includes techniques involving the principles, methods and procedures of counseling that assist the group in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns.

3. Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

C. Clinical Operations

1. Community-based group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Individual Counseling					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, approximately 20-30 minutes, face-to-face with the patient (appropriate license required)	90804				
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, approximately 45-50 minutes, face-to-face with the patient (appropriate license required)	90806				
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, approximately 75-80 minutes, face-to-face with the patient (appropriate license required)	90808				
Individual Psychotherapy, Interactive, Using Play Equipment, physical devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, in an Office or Outpatient Facility, Approximately 20-30 Minutes, Face-to-Face with the Patient (appropriate license required)	90810				
Individual Psychotherapy, Interactive, Using Play Equipment, physical devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, in an Office or Outpatient Facility, Approximately 45-50 Minutes, Face-to-Face with the Patient (appropriate license required)	90812				
Individual Psychotherapy, Interactive, Using Play Equipment, physical devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, in an Office or Outpatient Facility, Approximately 75-80 Minutes, Face-to-Face with the Patient (appropriate license required)	90814				

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the person in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the individual consumer and specified in the Individualized Recovery Plan. These services

address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills; and
6) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders	
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part II.	
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential	
Unit Value	Unit=1 encounter	
Reimbursement Rate	90804, 90810	$34.70
	90806, 90812	$62.46
	90808, 90814	$104.10
Initial Authorization	24 units	
Re-Authorization	24 units	
Authorization Period	180 days	
UAS: **Budget and Expense Categories**	Core Services Provider 128 – Adult Mental Health 728 – Adult Addictive Diseases	

Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. The individual's recovery goal that is to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and.** 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. Adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery Plan have been substantially met; **or** 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in individual's condition; **or** 5. Individual requires a service approach that supports less or more intensive need.
Service Exclusions	ACT and Crisis Residential
Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.

B. Staffing Requirements

1. Individual Counseling must be provided by a Mental Health Professional or Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services.
2. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Medication Administration					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Comprehensive Medication Services	H2010				
Therapeutic, Prophylactic or Diagnostic Injection (Specify Material Injected, Subcutaneous or Intramuscular)	90772				
Alcohol and/or Drug Services; Methadone Administration and/or Service (Provision of the drug by a licensed program)	H0020				

Definition of Service: The giving or administration of an oral medication or injection. Medication administration requires a physician's order, and medication must be administered by licensed medical personnel under the supervision of a physician. The service must include:

1. An assessment, by the licensed medical personnel administering the medication, of the individual's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the individual to the physician for a medication review.
2. Education to the individual and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the individual's plan of care.

This service may also include the administration of medication for opioid/methadone maintenance in accordance with state law (see also Opioid Maintenance Code).

Target Population	Individuals with Mental Illness Individuals with Substance Related Disorders Individuals with Co-occurring Mental Illness and Substance Related Disorders Individuals with Co-occurring Mental Illness and MR/DD Individuals with Co-occurring Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part II.

Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Unit Value	Unit=1 encounter
Reimbursement Rate	$24.67
Initial Authorization	With the submission of MICP Part I only-12 units With the submission of MICP Part I and III: H0020= 180 units 90772= 18 units H2010= 60 units
Re-Authorization	H0020= 180 units 90772 = 18 units H2010= 60 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 124 – Adult Mental Health 724 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places self/others in danger) or distressing (causes mental anguish or suffering); **and** 2. Individual is unable to self-administer prescribed medication because: a. Although individual is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; **or** b. Although individual is willing to take the prescribed medication, it is a Class A controlled substance (e.g. Methadone) which must be stored and dispensed by medical personnel in accordance with state law; **or** c. Due to severity of the mental illness/substance related disorder, individual is unwilling/unable to administer needed medication; **and** d. As evidenced by the individual's history, the individual would likely be in danger of harm to self, others or property without the medication
Continuing Stay Criteria	1. Individual continues to meet admission criteria. 2. If methadone is indicated, individual must meet criteria established by the Georgia Regulatory body for methadone administration programs (Department of Human Resources-DMHDDAD) and the Food and Drug Administration's guidelines for this service.

Discharge Criteria	1. Individual no longer needs medication; or 2. Individual is able to self-administer medication; or 3. Must meet criteria established by the Georgia Regulatory body for methadone administration programs (Department of Human Resources- DMHDDAD) and the Food and Drug Administration's guidelines for this service; and 4. Adequate continuing care plan has been established.
Service Exclusions	1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment or Crisis Residential. 3. Must not be billed while enrolled in CSP or ACT except if this Medication Administration service is utilized only for the administration of methadone (for Medicaid recipients). 4. For Medicaid recipients who need opioid maintenance, this service should be utilized in place of Opioid Maintenance.

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the individual's chart. Telephone orders are acceptable provided they are cosigned by the physician in accordance with DMHDDAD standards.
2. Documentation must support that the individual is being trained in the risk and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically or mentally unable to self-administer. This documentation may be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
4. This service does not include the supervision of self-administration of medication.
5. An agency that administers methadone must meet criteria established by the Georgia regulatory body for methadone administration programs (Department of Human Resources –DMHDDAD) and the Food and Drug Administrations guidelines for this service.

B. Staffing Requirements

1. Medication must be administered by licensed medical personnel under the supervision of a physician.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients who need opioid maintenance, this service should be utilized in place of Opioid Maintenance.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Nursing Assessment and Health Services					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Nursing Assessment/Evaluation (15 minutes)	T1001				
RN Services, 15 minutes	T1002				
LPN/LVN Services, 15 minutes	T1003				
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psychphysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, initial assessment	96150				
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psychphysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, re-assessment	96151				

Definition of Service: This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual. It includes:

1) Providing nursing assessments to observe, monitor and care for the physical, nutritional and psychological issues, problems or crises manifested in the course of an individual's treatment;
2) Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual to a physician for a medication review;
3) Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
4) Consulting with the individual and individual-identified family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
5) Educating the individual and any identified family about potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc);
6) Training for self-administration of medication; and
7) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by a Licensed Physician, Physician Assistant or Advanced Practice Nurse.

Target Population	Individuals with Mental Health issues/Serious Mental Illness and/or Substance Related Disorders Individuals with Mental Health issues/Serious Mental Illness and MR/DD Individuals with Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Unit Value	Unit=15 minutes
Reimbursement Rate	$24.44
Initial Authorization	With the submission of MICP Part I only-12 units With the submission of MICP Part I and III- 60 units
Re-Authorization	60 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Core Services Provider 123 – Adult Mental Health 723 – Adult Addictive Diseases
Admission Criteria	1. Individual presents symptoms that are likely to respond to medical/nursing interventions; **or** 2. Individual has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Individual continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; **or** 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; **or** 3. Individual demonstrates progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; **or** 3. Goals of the Individualized Recovery Plan have been substantially met; **or** 4. Individual requests discharge and individual is not in imminent danger of harm to self or others.
Service Exclusions	Intensive Day Treatment (Partial Hospitalization), Ambulatory Detoxification, ACT, and Crisis Residential.
Clinical Exclusions	Routine nursing activities that are included as a part of ambulatory

	detoxification, medication administration/methadone administration, or intensive day treatment.

Additional Service Criteria:

A. Required Components

1. Nutritional assessments indicated by an individual's confounding health issues may be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Registered Clinical Dietician.
2. This service does not include the supervision of self-administration of medication.

B. Staffing Requirements

1. These services must be offered by a licensed nurse within the scope of O.C.GA Practice Acts.
2. Practitioners providing this service are expected to maintain and utilize knowledge and skills regarding current research trends in best/evidence-based practices for psychiatric nursing and medication management.

C. Clinical Operations

1. Venipuncture billed under this service must include documentation that includes cannula size utilized, insertion site, number of attempts, location, and consumer tolerance of procedure.
2. All nursing procedures must include relevant consumer centered education regarding the procedure.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Pharmacy

Definition of Service: Directly or through a subcontract, prepare, compound, preserve, store, protect, and dispense prescribed medications; and assure appropriate instructions are provided as to the use of prescribed medications. These functions are coupled with patient and staff education and pharmacological monitoring to ensure safe and effective use of prescribed medications.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers with emphasis on priority populations. Requires a MICP Part I and possibly a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	
Reimbursement Rate	
Initial Authorization	
Re-Authorization	
Authorization Period	
UAS: **Budget and Expense Categories**	Core Services Provider 190 – Adult Mental Health 790 – Adult Addictive Diseases
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; **or** 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.
2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote consumer access in obtaining medication.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not a Medicaid Rehabilitation Option "service." Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting Requirements

1. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

Physician Assessment and Care					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Psychiatric Diagnostic Interview Examination (physician only)	90801				
Psychiatric Diagnostic Interview Examination (physician only)	90801	HA			
Psychiatric Diagnostic Interview Examination	90801	U3			
Psychiatric Diagnostic Interview Examination	90801	HA	U3		
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication (Physician only)	90802				
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication	90802	U3			
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication (Physician only)	90802	HA			
Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication (Physician only)	90802	HA	U3		
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes (Physician only)	90805				
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes	90805	U3			
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes (Physician only)	90805	HA			
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an	90805	HA	U3		

Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 20-30 Minutes (Physician only)			
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes (Physician only)	90807		
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes	90807	U3	
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes (Physician only)	90807	HA	
Individual Psychotherapy Insight Oriented Behavior Modifying and/or Supportive in an Office or Outpatient Facility with the Patient with Medical Evaluation, and Management Services, 40-50 Minutes (Physician only)	90807	HA	U3
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862		
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862	HA	
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862	GT	
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy (Physician Only)	90862	GT	HA
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	U3	
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	HA	U3
Pharmacologic Management, Including	90862	GT	U3

Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy					
Pharmacologic Management, Including Prescription, Use, and Review of Medication with no more than Minimal Psychotherapy	90862	GT	HA	U3	

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

a. Evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues),
b. A psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis),
c. Medical or psychiatric therapeutic services,
d. Assessment and monitoring of an individual's status in relation to treatment with medication, the development and authorization of the proposed support service array,
e. Assessment of the appropriateness of initiating or continuing services, and
f. Screening and/or assessment of any withdrawal symptoms for individuals with substance related diagnoses.

Individuals must receive appropriate medical interventions as prescribed and provided by a physician (or physician extender) that shall support the individualized goals of recovery as identified by the individual and their Individualized Recovery Plan.

Target Population	Individuals with Mental Illness or Substance Related Disorders	
Benefit Information	Available to all Core Customers. Requires a MICP Part I and possibly a MICP Part II.	
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services	
Unit Value	Unit=1 encounter	
Reimbursement Rate	90801	$118.92
	90802	$132.13
	90801U3	$101.08
	90802U3	$112.31
	90805	$79.28
	90805U3	$67.38
	90807	$118.89
	90807U3	$101.05
	90862, 90862GT	$39.64
	90862U3, 90862GTU3	$33.69
Initial Authorization	12 units	
Re-Authorization	12 units	
Authorization Period	180 days	

UAS: **Budget and Expense Categories**	Core Services Provider 122 – Adult Mental Health 722 – Adult Addictive Diseases
Admission Criteria	1. Individual has a mental illness or a substance-related disorder and has recently entered the service system; **or** 2. Individual is in need of annual assessment and re-authorization of service array; **or** 3. Individual has been prescribed medications as a part of the treatment array; **or** 4. Individual has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; **or** 5. Individual has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	1. Individual continues to meet the admission criteria; **or** 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; **or** 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; **or** 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual has withdrawn or been discharged from service; **or** 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	Not offered in conjunction with Intensive Day Treatment, ACT, or Crisis Stabilization Programs.
Clinical Exclusions	Services defined as a part of ambulatory detoxification, ACT, Crisis Stabilization Programs, and Intensive Day Treatment.

Additional Service Criteria:

A. Required Components

1. The "GT" code modifier refers to live telemedicine via videoconference link (i.e. video phones, web cams, etc.). It requires the presence of both parties at the same time. Audio and video must be involved with remote support sometimes also being present (but not billable simultaneously).
2. Telemedicine may not be utilized for an initial physician's assessment, but shall be utilized for ongoing physician evaluation and management.

B. Staffing Requirements

1. Practitioners providing this service are expected to maintain and utilize knowledge and skills regarding current research trends in best/evidence-based practices for psychiatry and medication management.
2. This service must be provided by a licensed medical physician with behavioral health training in accordance with the O.C.G.A and the Professional Practice Acts (excepting B.3.).
3. This service may also be provided by a Clinical Nurse Specialist or a Physician's Assistant with behavioral health training in accordance with O.C.G.A and the Professional Practice Acts. If an extender is used, other physician codes on the same day may only be used when the extender's notes identify the need for validation of clinical judgment. These interventions shall not be duplicative in nature.

C. Clinical Operations

1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).

D. **Service Access**

1. Telecommunications may be used to provide the service if the code has a GT modifier and if the remote site is designated as a Health Professional Shortage Area.

E. Additional Medicaid Requirements

1. For Medicaid recipients, only a licensed medical physician as described in the staffing requirements above may provide this service.
2. Currently, there are no other additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Mental Health and Addictive Disease Services

Adults' SPECIALTY Benefit Package

Ambulatory Substance Abuse Detoxification					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod 4**
Alcohol And/Or Drug Services; Ambulatory Detoxification	H0014				

Definition of Service: This service is the medical monitoring of the physical process of withdrawal from alcohol or other drugs in an outpatient setting for those individuals with an appropriate level of readiness for behavioral change and level of community/social support. It is indicated when the individual experiences physiological dysfunction during withdrawal, but life or significant bodily functions are not threatened.

This service must reflect ASAM (American Society of Addiction Medication) Levels I-D (Ambulatory Without Extended On-Site Monitoring) and II-D (Ambulatory With Extended Onsite Monitoring) and focuses on rapid stabilization and entry into the appropriate level of care/treatment based upon the ASAM guidelines placement criteria. These services may be provided in traditional Outpatient, Intensive Outpatient, Day Treatment, Intensive Day Treatment or other ambulatory settings.

Target Population	Adults and Older Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part II
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Unit Value	Unit=15 minutes
Reimbursement Rate	$24.44/unit
Initial Authorization	60 units
Re-Authorization	60 units
Authorization Period	30 days
UAS: **Budget and Expense Categories**	Addictive Disease Detox Services Provider 766 – Adult Addictive Diseases 866- C&A Addictive Diseases (for older adolescents)
Admission Criteria	Individual has a Substance Induced Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must be sufficient optimization in other dimensions of the individual's life to provide for safe detoxification in an outpatient setting, and individual meets the following three criteria: 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age,

	gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that withdrawal is imminent; and the individual is assessed to be at minimal (Level I-D) to moderate (Level II-D) risk of severe withdrawal syndrome outside the program setting and can safely be managed at this service level; and 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory detox services; and 3. Individual is assessed as likely to complete needed detoxification and to enter into continued treatment or self-help recovery as evidenced by: 1) Individual or support persons clearly understand and are able to follow instructions for care, and 2) Individual has adequate understanding of and expressed interest to enter into ambulatory detox services, or 3) Individual has adequate support services to ensure commitment to completion of detoxification and entry into ongoing treatment or recovery, or 4) Individual evidences willingness to accept recommendations for treatment once withdrawal has been managed.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can participate in self-directed recovery or ongoing treatment without the need for further medical or detoxification monitoring.
Discharge Criteria	1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual/family requests discharge and individual is not imminently dangerous; or 4. Withdrawal signs and symptoms have failed to respond to treatment and have intensified (as confirmed by higher scores on CIWA-Ar or other comparable standardized scoring system) such that transfer to a more intensive level of detoxification service is indicated, or 5. Individual has been unable to complete Level I-D/II-D despite an adequate trial.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Ambulatory Detoxification is not to be billed separately as Medication Administration.)
Clinical Exclusions	1. Substance Abuse issue has incapacitated the individual in all aspects of daily living, there is resistance to treatment as in ASAM Dimension 4, relapse potential is high (Dimension 5), and the recovery environment is poor (Dimension 6). 2. Concomitant medical condition and/or other behavioral health issues warrant inpatient/residential treatment.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate ambulatory detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.
3. Programmatic philosophy must reflect emphasis on the development of a Plan of Care, which provides services in the least restrictive most empowering setting. This is an essential consideration for each individual's plan of care. This empowers individuals by fostering independence.

B. Staffing Requirements

1. Services must be provided only by nursing or other licensed medical staff under supervision of a physician.

C. Clinical Operations

1. The severity of the individual's symptoms, level of supports needed, and the physician's authorization for the service will determine the setting, as well as the amount of nursing and physician supervision necessary during the withdrawal process. The individual may or may not require medication, and 24-hour nursing services are not required. However, there is a contingency plan for "after hours" concerns/emergencies.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Assertive Community Treatment					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Assertive Community Treatment, Per 15 minutes	H0039				

Definition of Service: ACT is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in public hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, and rehabilitative crisis, treatment and community support interventions/services that are available 24-hours/7 days a week. The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence based practices for service delivery and support that have the capacity to adequately address co-occurring disorders/issues if needed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices for ACT. Services are directed towards the identified individual consumer and his or her behavioral health care needs based upon the Individualized Recovery Plan and, based on the needs of the individual, may include (in addition to those services provided by other systems):

1. Assistance to the individual in the development of the Individualized Recovery Plan (IRP);
2. Psychoeducational and instrumental support to individuals and their identified family;
3. Crisis assessment, support and intervention; and
4. Individualized interventions, which may include:
    a. Identification, with the consumer, of barriers that impede the development of skills necessary for independent functioning in the community as well as strengths which may aid the individual in recovery;
    b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
    c. Service and resource coordination to assist the individual in gaining access to necessary rehabilitative, medical and other services;
    d. Family counseling/training for individuals and their families (as related to the person's IRP);
    e. Assistance in the acquisition of symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills);
    f. Assistance with financial management skill development;
    g. Assistance with personal development and school/work performance;
    h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psychoeducational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc);

i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);
j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues; and
k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), decreased medication side effects, improved social integration and functioning, and increased movement toward self-defined recovery.

Target Population	Adults with Serious and Persistent Mental Illness, Adult with Co-Occurring Substance Related Disorders and Serious and Persistent Mental Illness Adults with Co-Occurring Serious and Persistent Mental Illness and MR/DD
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part II
Practice Guidelines	Available to those with LOCUS scores: 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Unit Value	Unit=15 minutes
Reimbursement Rate	$24.64
Initial Authorization	480 units
Re-Authorization	480 units
Authorization Period	180 days
UAS: Budget and Expense Categories	Intensive Treatment Services Provider 152 – Adult Mental Health
Admission Criteria	1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder, because these illnesses more often cause long-term psychiatric disability; **and** 2. Individuals with significant functional impairments as demonstrated by the **inability to consistently engage in at least two of the following:** a. Maintaining personal hygiene;

	b. meeting nutritional needs; c. caring for personal business affairs; d. obtaining medical, legal, and housing services; e. recognizing and avoiding common dangers or hazards to self and possessions; f. persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or other relatives; g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); h. Maintaining a safe living situation (e.g., repeated evictions or loss of housing); **and** 3. Individuals with **one or more of the following problems** that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services. b. Persistent, recurrent, severe, or major symptoms (e.g., affective, psychotic, suicidal). c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3, III.5). d. High risk or a recent history of criminal justice involvement (e.g., arrest and incarceration). e. Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless. f. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available. g. Inability to participate in traditional clinic-based services; **and** 4. A lower level of service/support has been tried or considered and found inappropriate at this time.

Continuing Stay Criteria	1. Individual meets the requirements above; **and** 2. Continued inability to participate in traditional office setting or community setting at a less intense level of service/supports; **and** 3. Substandard housing, homeless, or at imminent risk of becoming homeless related to the behavioral health issues
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual no longer meets admission criteria; **or** 3. Goals of the Individualized Recovery Plan have been substantially met; **or** 4. Individual requests discharge and is not in imminent danger of harm to self or others, **or** 5. Transfer to another service/level of care is warranted by a change in individual's condition, **or** 6. Individual requires services not available in this level of care.
Service Exclusions	1. ACT is a comprehensive team intervention and most services are excluded. Peer Supports, Group Training/Counseling, and Diagnostic/Functional Assessment are the exceptions. On an individual basis, a limited amount of services can be provided to ACT consumers to allow an individual to transition to and from ACT and other community services (e.g., Psychosocial Rehabilitation, Community Supports Team & Individual). The transition plan must be adequately documented in the Individualized Recovery Plan and clinical record. 2. Those receiving Medicaid MR Waivers are excluded from the service.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance related disorder.

Additional Service Criteria:

A. Required Components

1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings. Team meetings must be held a minimum of 3 times a week.
2. Services and interventions must be highly individualized and tailored to the needs and preferences of the individual with the goal of maximizing independence and supporting recovery. At lease 60% of all services must involve face-to-face contact with consumers. At least 80% of face-to-face services must be provided in locations

other than the office (including the individual's home, based on individual need and preference and clinical appropriateness.

3. It is recommended that the ACT Team provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis, and all individuals participating in ACT must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual once a month for the purpose of symptom assessment/management and management of medications.
4. Service may be delivered by a single team member to 2 ACT consumers at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.5.).
5. The only scenario in which this service may be offered to more than 2 people is when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT). For this to be allowable, there must be an identified cohort of ACT participants whose clinical needs and recovery goals justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than 8 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as ACT. This may be offered no more than 2 hours in any given week. (Effective April 2004 through June 2005).
6. ACT recipients can receive limited Group Training/Counseling (up to 8 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT). For this to be allowable, the ACT participants must have clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than 8 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as Group Training/Counseling. This may be offered for no more than 2 hours in any given week (Effective June 2005). Only ACT consumers are permitted to attend these group services.

B. Staffing Requirements

1. Minimum staffing requirements for Assertive Community Treatment include the following positions:
    - A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be a Mental Health Professional. The Team Leader who is a registered nurse must hold a four-year degree (BSN).
    - A Psychiatrist on a full-time or part-time basis. The psychiatrist must provide clinical and crisis services to all team consumers, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment.
    - One fulltime equivalent Registered Nurse who must provide nursing services for all team consumers and who must work with the team to monitor each individual's clinical status and response to treatment.
    - One-half to one fulltime equivalent Substance Abuse Professional who must work on a fulltime or half-time basis to provide or access substance abuse supports for team consumers.

- A clinically trained practitioner who is either a Mental Health Professional or a Licensed Clinician and who must provide individual and group support to team consumers (this position is in addition to the Team Leader).
- One certified Peer Specialist who provides rehabilitation and recovery support functions
- One to three paraprofessionals (or professionals) who must provide services under the supervision of a Licensed Clinician; one of these staff must be a Vocational Rehabilitation Specialist.

2. The Substance Abuse Professional, Mental Health Professional, Peer Support Specialist, and the paraprofessionals function as primary practitioners for a caseload of consumers. The Team Leader, Registered Nurse, and Vocational Rehabilitation Specialist function as primary practitioners for a partial caseload of consumers and provide support to all team recipients.
3. The ACT team maintains a small consumer-to-clinician ratio, of no more than 12 consumers per staff member. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.
4. Documentation must demonstrate that all team members are engaged in the support of each consumer served by the team (excluding the SAP if substance related issues have been ruled out).

C. Clinical Operations

1. ACT Teams must be designed to deliver services in various environments, such as homes, schools, jails, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
2. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in those settings.
3. Each ACT Team provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. The organization must have an Assertive Community Treatment Organizational Plan that the following descriptions:

- Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff
- Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated
- Hours of operation, the staff assigned, and types of services provided to consumers, families, and/or guardians
- How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan
- Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)

D. Service Accessibility

1. Services must be available 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services.
2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.
3. An ACT staff member skilled in crisis intervention must provide on-call coverage.
4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Community Based Inpatient Psychiatric and Substance Detoxification Services					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Psychiatric Health Facility Service, Per Diem	H2013				

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Adults with a serious mental illness Adults with a Substance Related Disorder Adults with Co-occurring SMI and a Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP Part II
Practice Guidelines	Available to those with LOCUS scores: 6: Medically Managed Residential
Unit Value	Per Diem
Reimbursement Rate	Per negotiation
Initial Authorization	5 days
Re-Authorization	3 days
Authorization Period	5 days
UAS: **Budget and Expense Categories**	Adult Crisis Services Provider 135 – Adult Mental Health 735 – Adult Addictive Diseases
Admission Criteria	1. Individual with serious mental illness/SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Individual's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Individual is assessed as meeting diagnostic criteria for a Substance Induced Disorder according to the latest version of the DSM; and one or more of the following: A. Individual is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the

	individual, as evidenced by: i. A detoxification regimen or individual's response to that regimen that requires monitoring or intervention more frequently than hourly, or ii. The individual's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer meets admission and continued stay criteria; or 3. Individual requests discharge and individual is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.
Clinical Exclusions	Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

G. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2
2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.

H. Staffing Requirements

1. Detoxification services must be provided only by nursing or other licensed medical staff under supervision of a physician.

I. Clinical Operations

J. Service Access

K. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service.

L. Reporting Requirements

1. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

Community Support – Team

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	H2015	HT			

Definition of Service: Community Support Team is a recovery oriented, intensive, community-based rehabilitation and outreach service available 24 hours per day, 7 days per week, that provides treatment and restorative/recovery focused interventions to assist individuals in gaining access to necessary services; in managing (including teaching skills to self-manage) their psychiatric and/or addictive illnesses, in developing optimal independent community living skills, and in setting and attaining consumer-defined recovery goals. Services are provided utilizing a team approach, and must be documented in the Individualized Recovery Plan (IRP). Based upon the goals and needs of the individual, services may include:

1. Assistance to the individual in the development of the Individualized Recovery Plan (IRP);
2. Psychoeducational and instrumental support to individuals and their identified natural supports/families;
3. Crisis assessment, support and intervention; and
4. Individualized interventions, which may include:
    a. Identification, with the consumer, of strengths which may aid the individual in recovery, as well as barriers that impede the development of skills necessary for independent functioning in the community;
    b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
    c. Service and resource coordination to assist the individual in gaining access to necessary rehabilitative services, medical services, wellness supports, general entitlement benefits, or other services;
    d. Family counseling/training for individuals and their families (as related to the person's IRP);
    e. Individualized, restorative one-to-one therapeutic interventions to develop interpersonal/social, community coping and independent living/functional skills (including adaptation to home and work environments);
    f. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues;
    g. Assistance in the acquisition of symptom monitoring, illness self-management skills, and wellness behaviors (which may include medication monitoring and assistance in development of self-medication skills) in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living;
    h. Assistance with financial management skill development if this is an identified barrier which has been impacted by the mental illness or addiction;
    i. Assistance with personal development, social relationships, and work performance if these are identified barriers which have been impacted by the mental illness or

addiction;

j. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psychoeducational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc); and
k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

Community Support Teams may serve as a step down service for individuals transitioning from Assertive Community Treatment services or other higher levels of care, or for those with psychiatric hospitalizations/repeated detoxification incidence in the past 18 months. The service is provided to individuals to decrease hospitalizations and crisis episodes and increase community tenure/independent functioning; increase time working or with social contacts; and personal satisfaction and autonomy. Through supports based on identified, individualized needs, the individual will reside in independent or semi-independent living arrangements and be engaged in the recovery process.

Target Population	Adults experiencing: Serious Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Serious Mental Illness Co-Occurring Serious Mental Illness and Mental Retardation/DD Co-occurring Substance-Related Disorders and Mental Retardation/DD,
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part II.
Practice Guidelines	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Unit Value	Unit=15 minutes
Reimbursement Rate	$20.11/unit
Initial Authorization	480 units
Re-Authorization	480 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Adult Intensive Treatment Services Provider 151 – Adult Mental Health 751 – Adult Addictive Diseases
Admission Criteria	Individuals with moderate to severe symptoms, **and 4 or more of the following conditions:** • High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g.,

	2 or more admissions per year), or extended hospital stay (30 days within the past year), or psychiatric emergency services. • High use of detoxification services (e.g. 2 or more episodes per year) • History of inadequate follow-through with elements of a Recovery Plan related to risk factors, including lack of follow-through taking medications, following a crisis plan, or maintaining housing. • Medication resistant due to intolerable side effects or illness prohibits consistent self-management of medications. • Legal issues such as conditional release for nonviolent offense or history of failures to show up in court. • Homeless or at high risk of homelessness due to residential instability. • Behavioral health issues have not shown improvement in traditional outpatient treatment and require coordinated clinical and supportive interventions; • Clinical evidence of suicidal gestures and/or ideation in past 3 months. • Ongoing inappropriate public behavior within the last 3 months. • Self-harm or threats of harm to others within the last year. • Evidence of significant complications such as cognitive impairment, behavioral problems, or medical conditions. • A lower service intensity has been tried or considered and found inappropriate at this time.
Continuing Stay Criteria	1. Same as above.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. No longer meets admission criteria; **or** 3. Goals of the Individualized Recovery Plan have been substantially met **or**; 4. Individual requests discharge and is not in imminent danger of harm to self or others; **or** 5. Transfer to another service/level of care is warranted by change in individual's condition; **or** 6. Individual requires services not available in this level of care.
Service Exclusions	Not offered in conjunction with Assertive Community Treatment.

Clinical Exclusions	1. Presence of any psychiatric condition requiring a more intensive level of care. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Component

1. Community Support Teams offer a comprehensive set of psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team provides community support services that are interwoven with rehabilitative efforts.
2. Services and interventions are highly individualized and tailored to the needs and preferences of the individual, with the goal of maximizing independence and supporting recovery.
3. The Community Support Team must see each consumer, at a minimum, twice a month, with one encounter focusing on symptom assessment/management and management of medications. Individuals must also receive a telephone check-in call once a month.
4. At least 60% of services are provided face-to-face with consumers and 80% of all face-to-face services are delivered in non-clinic settings during the authorization period.
5. There must be bi-monthly staffings, attended by an MHP/SAM, which specifically discuss the status of each individual consumer enrolled in the service. Evidence of these staffings must be documented in each consumer's chart/record.

B. Staffing Requirements

1. Minimum staffing requirements for a Community Support Team include the following:
    a. Fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be a licensed/credentialed (CACII) Mental Health Professional or Substance Abuse Manager.
    b. Fulltime equivalent (FTE) certified Peer Support Specialist.
    c. Paraprofessionals who work under the supervision of either a Mental Health Professional or a Substance Abuse Manager and who work on the team in sufficient fulltime equivalents to meet the required consumer-to-staff ratio.
2. Community Support Teams must be comprised of a minimum of 3 and a maximum of 4 staff members meeting the requirements above (including the FTE MHP/SAM Team leader).
3. The Community Support Team maintains a recommended consumer-to-practitioner ratio of no more than 18 consumers per staff member. Staff-to-

consumer ratio takes into consideration evening, weekend and holiday hours, needs of special populations, and geographical areas to be served.

4. Documentation must demonstrate that at least 2 team members are actively engaged in the support of each consumer served by the team. One of these team members must be appropriately licensed/credentialed (CACII) to provide any professional counseling and treatment modalities/interventions needed by the consumer and must provide these modalities/interventions as clinically appropriate according to the needs of the consumer.

C. Clinical Operations

1. Community Support Team services provided to children and youth must include coordination with family and significant others and with other systems of care such as school system, juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
2. Community Support Team providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the consumer wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
3. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. Each Community Support Team provider must have policies and procedures for the provision of community-based services, including means by which these services and individuals are targeted for such efforts. The organization also must have policies and procedures for protecting the safety of staff that engage in these activities.
6. The organization must have a Community Support Team Organizational Plan that describes:
    a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff
    b. Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated

c. Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)
d. Hours of operation, the staff assigned and types of services provided to consumers, families, and/or guardians
e. How the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan.

7. For individuals with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.

D. Service Accessibility

1. This service must be available 24 hours a day, 7 days a week with emergency response coverage. The team must be able to rapidly respond to early signs of relapse and decompensation. An on-call CST staff member skilled in crisis intervention must provide coverage.
2. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Consumer/Family Assistance					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Mental Health Services, Not Otherwise Specified	H0046				

Definition of Service: Individuals may need a range of goods and community support services to fully benefit from mental health and addictive disease services. This time-limited service consists of goods and services purchased/procured on behalf of the consumer (e.g. purchase of a time-limited mentor, a one-time rental payment to prevent eviction/homelessness, a utility deposit to help an individual move into the community and/or their own housing, environmental modification to the individual's home to enhance safety and ability to continue living independently etc) that will help promote individual functional enhancement to the benefit of the individual and his/her behavioral health stability. The goods/services procured must provide a *direct and critical* benefit to the individualized needs of the consumer, in accordance with the IRP, and lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status, or prevent an imminent crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc). The service is not intended to pay for/provide ongoing service programming through the provider agency.

Target Population	Adults defined as Core Customers of Ongoing Services who are diagnosed with: Mental Illness Substance Related Disorders Co-Occurring Mental Illness and Substance Related Disorders Co-Occurring Mental Illness/Substance Related Disorders and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part II.
Practice Guidelines	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	Variable in accordance with Items C.6. below
Reimbursement Rate	Variable in accordance with Items C.6. below
Initial Authorization	While the actual assistance should be very short-term in nature, this service can be authorized as part of a 180 day Recovery plan.
Re-Authorization	One within a single fiscal year.
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Adult Consumer/Family Support Services Provider 137 – Adult Mental Health 737 – Adult Addictive Diseases

Admission Criteria	1. Individual must meet Core Customer criteria for Ongoing services, **and** 2. Individual must be in need of a specific good or service that will directly improve functioning (e.g. directly lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc.), **and** 3. Individual or provider must exhaust all other possible resources for obtaining the needed goods/services—this service provides payment of last resort, **and** 4. Individual has not received this service for more than one other episode of need during the current fiscal year.
Continuing Stay Criteria	1. Individual must continue to meet Core Customer criteria for Ongoing services, and 2. Individual must continue to be in need of the same specific good or service as when enrolled in Consumer/Family Assistance, that will directly improve functioning (e.g. directly lead to an increase in specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or obtain more independent living), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc.), and 3. Individual or provider must continue to lack any other possible resources for obtaining the needed goods/services.
Discharge Criteria	1. Individual no longer meets Core Customer criteria for Ongoing services, **or** 2. Individual no longer continues to be in need of the good or service, **or** 3. Individual has received the good in the allotted amount or service for the allotted timeframe as described below in "Additional Service Criteria" # 3, **or** 4. The individual requests discontinuance of the service.
Service Exclusions	1. Goods and services that are included as a part of other services the individual is enrolled in or could be enrolled in are excluded.
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. This service must not pay for the regular staffing of specific programs or services in the provider's agency.
2. Service may pay for a 1:1 mentor, etc for an individual consumer, within the following limits:
   a. Other means are not available to pay for the mentor, etc., such as state funding, Medicaid, self-pay or private insurance.
   b. The mentor, etc. cannot be used to supplement the staffing of any program or service in the provider agency.
   c. The mentor, etc. cannot be used as a 1:1 staff for the consumer during the times the consumer is attending other programming/services offered by the provider agency.

C. Clinical Operations

1. This service must not pay for transportation to MH/DD/AD services.
2. This service must not pay for the operating, programmatic, or administrative expenses of any other program or service offered by the provider agency.
3. Individual cannot receive this service for more than two episodes of need per fiscal year.
4. Services obtained (e.g. a mentor, etc.) are intended to be of short duration and must be provided through this service for no longer than 3 months, or until the direct consumer benefit is realized, whichever occurs sooner.
5. Each type of necessary good obtained through this service is intended to be of short duration and must be purchased for no longer/in no greater amount than is reasonably necessary to avoid/resolve the immediate crisis or achieve the targeted increase in functioning. Some items have specific limits that cannot be surpassed during a single episode of need. The least duration and/or amount necessary of such items should be provided. Up to:
   - one month's rental/mortgage assistance;
   - one month's assistance with utilities and/or other critical bills;
   - one housing deposit;
   - one month's supply of groceries (for the individual);
   - one month of medications;
   - one assistive device (unless a particular device is required in multiple according to commonly understood definition/practice such as a hearing aide for each ear, a one month supply of diabetic supplies etc);
   - one to two weeks' worth of clothing.

   Similar guidelines should be used with other items not on this list.
6. The maximum yearly monetary limit for this service is $2000 per individual per fiscal year. Individuals leaving an institution after a stay of at least 60 days who have had their benefits suspended or who do not yet have income or other benefits established may need greater assistance than the allowances indicated above for rent, bills,

groceries and other items/services. For such individuals, multiple months of rent, bills, groceries, services etc may be purchased, at a maximum yearly monetary limit of $5000 per individual per fiscal year.

7. Eligibility for the Consumer/Family Assistance service does not equate to an entitlement to the service. Prioritizing eligible individuals to receive services is the responsibility of the service provider. A standard protocol must be utilized by the service provider to assess and approve the individual's needs in regard to 1) the criticalness of the need(s) in terms of the individual's functioning and ability to return to/remain in the community, and 2) the individual's or provider's ability to obtain the needed goods or services through other viable means.

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service.

F. Reporting Requirements

1. The agency must submit a monthly report to the DMHDDAD in a specified format.
2. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Documentation that authorized goods/services are not available through other viable means must be made in the individual's chart.
2. Details regarding the goods/services procured and resulting benefit to the individual consumer must be documented in the individual's chart.

Crisis Stabilization Program ("Crisis Residential Services" under Medicaid Rehab Option)					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem	H0018	U2			

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

1) Psychiatric medical assessment;
2) Crisis assessment, support and intervention;
3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
4) Medication administration, management and monitoring;
5) Brief individual, group and/or family counseling; and
6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the Division of MHDDAD as an emergency receiving and evaluation facility

Target Population	Adults experiencing: Severe situational crisis Severe Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation,
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 4: Medically Monitored Non-Residential (residential detox only) 5: Medically Monitored Community Residential
Unit Value	Unit=1 day
Reimbursement Rate	$209.22/unit
Initial Authorization	20 days
Re-Authorization	
Authorization Period	20 days
UAS: **Budget and Expense Categories**	Adult Crisis Services Provider 134 – Adult Mental Health 734 – Adult Addictive Diseases

Admission Criteria	1. Treatment at a lower level of care has been attempted or given serious consideration; **and #2 and/or #3 are met**: 2. Individual has a known or suspected illness/disorder in keeping with target populations listed above; **or** 3. Individual is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; **and one or more of the following**: 4. Individual presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; **or** 5. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; **or** 6. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; **or** 7. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	1. Individual no longer meets admission guidelines requirements; **or** 2. Crisis situation is resolved and an adequate continuing care plan has been established; **or** 3. Individual does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following: • Methadone Administration as part of Medical Administration, Diagnosis/Functional Assessment,
Clinical Exclusions	1. Individual is not in crisis. 2. Individual does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.

Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Programs (CSP) providing medically monitored short-term residential psychiatric stabilization and detoxification services, shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the Division of MHDDAD.

2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders* "Core Requirements for All Providers" and DMHDDAD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. Individual referred to a CSP must be evaluated by a physician within 24 hours of the referral.
4. Maximum stay in a crisis bed is 10 days (excluding Saturdays, Sundays and holidays) for adults (an adult occupying a transitional bed may remain in the CSP for an unlimited number of additional days if the date of transfer and length of stay in the transitional bed is documented).
5. Individuals occupying transitional beds must receive services from outside the CSP (i.e. community-based services) on a daily basis.
6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
7. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.

B. Staffing Requirements

1. Crisis Stabilization Program (CSP) Services must be provided by a physician or a staff member under the supervision of a physician, practicing within the scope of State law.
2. A CSP must employ a fulltime Nursing Administrator who is a Registered Nurse.
3. A CSP must have a Registered Nurse present at the facility at all times.
4. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
5. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. CSP must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CPS and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CPS is unable to stabilize the individual.
2. CSPs must follow the seclusion and restraint procedures included in the Division's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."

3. For individuals with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSP, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Crisis Stabilization Programs are billed as Crisis Residential Services for Medicaid recipients.
2. For those CSPs that bill Medicaid, Crisis Residential Services are limited to 16 beds.
3. Beds designated as transitional beds are not billed as "Crisis Residential" but are billed under the service Residential Rehabilitative Supports II.

F. Reporting Requirements

1. Providers must designate either CSP bed use or transitional bed use in MICP submissions.
2. All other applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In order to bill for the per diem rate, the consumer must have participated in the program for a minimum of 8 hours in the identified 12:00AM to 11:59PM day
2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
3. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

Mental Health Intensive Day Treatment (Partial Hospitalization)					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Mental Health Partial Hospitalization, Less Than 24 Hours	H0035				

Definition of Service: Provides for the stabilization of psychiatric impairments with time limited, intensive, clinical services provided by a multi-disciplinary team in a clinic or facility-based setting available at least 5 days per week. This service includes the capacity for the administration of medication as necessary for an individual. Candidates for these services have adequate natural/community support systems and do not have behavioral health issues that are imminently dangerous. Services include physician and nursing services available onsite on a daily basis. Mandatory services include medical services, family contact, group counseling/training, nursing services, medical management and continuing care planning. Other available services include family counseling, individual counseling, and education/training as it pertains to the alleviation of identified behavioral health problems. Treatment is based on the needs and goals of the individual as articulated in the Individualized Recovery Plan. This service may be offered for a maximum of 5 hours per day.

The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence based practices for service delivery and support that are based on the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices for adult intensive day treatment programs.

Target Population	Adults with Serious and Persistent Mental Illness Adults with Serious and Persistent Mental Illness and a Co-occurring Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Unit Value	Unit=1 hour
Reimbursement Rate	$21.74
Initial Authorization	75 units (21 days)
Re-Authorization	75 units (21 days)
UAS: **Budget and Expense Categories**	MH Intensive Day Services Provider 159 – Adult Mental Health

Admission Criteria	1. Individual must have primary behavioral health issues that may need medical and treatment services to decrease risk factors including suicidal and/or homicidal ideation or aggressive behavior; or all of the following: 2. Presence of frequent or severe symptoms such as psychosis, mood disorders (e.g., depression, severe withdrawal), anxiety, and addiction (e.g. alcohol, drug use) that require medical stabilization; and 3. Community supports are sufficient to allow participation in the program versus a higher intensity service; and 4. Level of functioning precludes provision of services in less restrictive service (active symptoms disruptive to others); and 5. Reasonable expectation that the individual can improve and demonstrably within 7 – 21 days.
Continuing Stay Criteria	1. Primary behavioral health issues that continue to present a risk or danger to themselves or others including suicidal and/or homicidal ideation or aggressive behavior; or 2. Continued presence of frequent or severe symptoms such as psychosis, mood disorders (e.g., depression, severe withdrawal), anxiety and addiction (e.g., alcohol, drug use) that require medical stabilization; or 3. Ongoing need for psychiatric stabilization that includes the need for nursing/physician participation.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Psychiatric symptoms are stabilized; **or** 3. Medication is titrated so that there is no longer a need for daily nursing oversight; **or** 4. The individual no longer presents significant risk factors; or 5. The consumer/family requests discharge from services and individual is not in imminent danger of harm to self or others; or 6. The consumer/family requests services not available through this milieu; **or** 7. Individual is able to participate in recovery or rehabilitation planning and services, and is not in imminent danger of harm to self or others; **or** 8. Individual has a better awareness of illness/symptoms and medications and is knowledgeable of ways to manage symptoms and is not in imminent danger of harm to self or others.
Service Exclusions	Not offered in conjunction with ACT, SA Adult Day Services, Medication Administration, Physician Assessment, Nursing Assessment, Individual, Group, and Family Counseling, Psychosocial Rehabilitation, and Crisis Stabilization Programs.

Clinical Exclusions	1. Level of functioning precludes more intensive interventions. 2. Individuals who require one-to-one supervision for protection of self or others (e.g. inpatient psychiatric care or crisis residential services) 3. Unless clearly documented evidence of an acute psychiatric episode, primary diagnosis of Substance Abuse, Developmental Disability or of delirium, dementia, autism or organic mental disorder. 4. Legal status requiring a locked facility.

Additional Service Criteria:

A. Required Components

1. The service must operate at an established clinic site.
2. This service is distinguished by the need for the level of psychiatric medical support, which, if not present for the individual served, would indicate a lesser level of service.
3. Face-to-face RN services must be available daily as indicated below.
4. Face-to-face Physician services must be available as required to meet supervision and clinical operations requirements indicated below.
5. The service must be able to handle crises situations of a psychiatric medical nature to the extent that individuals and staff are safe from harm.

B. Staffing Requirements

1. The program must be under the supervision of a Physician.
2. Services must be provided and/or activities led by staff who are:
   - a Registered Nurse (RN)
   - a Mental Health Professional (MHP)
   - a Social Services Technician (SST) II or above under the supervision of an MHP. An SST II is someone who has a high school diploma plus 90 hours of college credits (at least 15 of which are in psychology, social work, or related human services fields) and 3 years experience in a social services setting OR has a bachelors degree plus 1 year experience in a social services setting OR
   - a Peer Specialist under the supervision of an MHP.
3. There must be an RN or MHP present face-to-face at all times the service is in operation, regardless of the number of consumers participating.
4. The maximum face-to-face ratio cannot be more than 20 consumers to 1 MHP or RN based on average daily attendance.
5. The maximum face-to-face ratio cannot be more than 8 consumers to 1 direct service/program staff, based on average daily. MHPs are included in the staff count for purposes of calculating this ratio.
6. Nursing services must be available daily, but are not counted for staff to consumer ratios unless the RN is available face-to-face during the entire operation of the service.

7. All staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.
8. An RN or Physician must be available at the site or program facility and able to be face-to-face within 15 minutes of a request for assistance (rapid response).
9. An RN or Physician may be shared with other programs as long as they are available as required for supervision, clinical operations, and rapid response, and as long as they are not counted in consumer to staff ratios in 2 different programs operating at the same time.

C. Clinical Operations

1. This service must operate within an established clinic site approved to bill Medicaid for services.
2. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing (except as provided above for RN and Physician), program description, and physical space.
3. Every admission must be documented.
4. A Physician's participation in support of the individual must be documented at least 3 times per week, at least 2 of which must be face-to-face. Every physician contact including medication prescription and administration must be documented.
5. An RN's progress note showing participation in support of the consumer must be documented at least daily for the first 7 days and at least 2 times in each subsequent 7-day period. Every nursing contact, including medication administration must be documented.
6. In addition to other documentation requirements, a daily progress note must be written for each consumer by some member of the direct service/program staff.
7. A weekly summary and signoff on supervised staff's notes must be documented by the supervising MHP.
8. Daily attendance of each individual participating in the program must be documented showing number of hours in attendance for billing purposes.
9. Transition planning for less intensive service options must begin at the onset of this service delivery and the clinical record must document this planning and the activities undertaken to support the transitional process.
10. When this service is used to transition an individual from 24-hour intensive supports, documentation must demonstrate careful planning to maximize the effectiveness of this service and the activities undertaken to support the transitional process.
11. The program must have an Intensive Day Treatment Organizational Plan that includes the following information:
    - Program's clinical philosophy
    - Hours of operation, the staff assigned, and the types of services and activities provided for both consumers and families
    - How individuals are involved in treatment planning and services
    - How the plan for services will be modified or adjusted to meet the needs specified in each Individualized Recovery Plan
    - How the individual's and family's requests for discharge and change in services or service intensity are handled.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Opioid Maintenance Treatment					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Alcohol and/or Drug Services; Methadone Administration and/or Service (Provision of the drug by a licensed program)	H0020				

Definition of Service: An organized, usually ambulatory, addiction treatment service for opiate-addicted individuals. The service includes individualized treatment, resource coordination, and health education (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]) (For Medicaid consumers, the actual administration of the opioid maintenance medication is conducted under the Medication Administration service code). The nature of the services provided (such as dose, level of care, length of service or frequency of visits) is determined by the patient's clinical needs, but such services always include regularly scheduled psychosocial treatment sessions and daily medication visits within a structured program. Services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. Length of service varies with the severity of the individual's illness, as well as his or her response to and desire to continue treatment. Treatment with methadone or LAAM is designed to address the individual's need to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the Individualized Recovery/Resiliency Plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery and inhibit the individual's ability to cope with life.

Target Population	Individuals with a diagnosis of Opioid Dependence.
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Unit Value	Unit=1 encounter
Reimbursement Rate	$24.67
Initial Authorization	With the submission of MICP Part I only-12 units With the submission of MICP Part I and II: 180 units
Re-Authorization	180 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Opioid Maintenance Treatment Provider 763 – Adult Addictive Diseases
Admission Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.

Continuing Stay Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Discharge Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Service Exclusions	
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Must meet and follow criteria established by the Georgia regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Core providers who are approved to bill Medication Administration may bill H0020 for Medicaid recipients who receive this service.

F. Reporting Requirements

1. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

Peer Support Services					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Self-Help/Peer Services	H0038				

Definition of Service: This service provides structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are consumer motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring consumer purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into consumer strengths related to illness self management, by emphasizing hope and wellness, by helping consumers develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting consumers with relapse prevention planning. A Consumer Peer Support Center may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which consumers can meet and provide mutual support.

A Peer Support Center must be operated at a minimum of 3 days per week, no less than 4 hours per day during those three days. Any agency may offer additional hours on additional days in addition to these minimum requirements.

Target Population	Adults with serious mental illness or co-occurring mental illness and substance related disorders Adolescents transitioning into adulthood with SED or co-occurring SED and substance related disorders
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.
Practice Guidelines	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential
Unit Value	Unit=15 minutes
Reimbursement Rate	$1.53
Initial Authorization	3600 units
Re-Authorization	3600 units
UAS: **Budget and Expense Categories**	<u>Peer Support Services Provider</u> 138 – Adult Mental Health 238 – C&A Mental Health (for older adolescents) 738 – Adult Addictive Diseases 838 – C&A Addictive Diseases (for older adolescents)

Admission Criteria	1. Individual must have a primary mental health issue; **and one or more of the following:** 2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; **or** 3. Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; **or** 4. Individual may need assistance and support to prepare for a successful work experience; **or** 5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; **or** 6. Individual may need peer supports to develop or maintain daily living skills.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery Plan have been substantially met; **or** 3. Consumer/family requests discharge; **or** 4. Transfer to another service/level is more clinically appropriate.
Service Exclusions	Crisis Stabilization Program (however, those utilizing transitional beds within a Crisis Stabilization Program may access this service).
Clinical Exclusions	1. Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; **or** 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury

Additional Service Criteria:

A. Required Components

1. A Peer Supports service may operate as a program within:
    - A freestanding Peer Support Center
    - A Peer Support Center that is within a clinical service provider
    - A larger clinical or community human service provider administratively, but with complete programmatic autonomy.
2. A Peer Supports service must be operated for no less than 12 hours a week, no less than 4 hours per day, no less than 3 days per week, typically during day, evening and weekend hours.

3. The governing board of a freestanding Peer Center must be composed of 75% consumers and represent the cultural diversity of the population of the community being served. The board is encouraged to have either board members or operating relationships with someone with legal and accounting expertise. For programs that are part of a larger organizational structure that is not consumer led and operated, the Peer Supports Program must have an advisory body with the same composition as a freestanding Peer Center's board. The board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements, and sponsoring agency operating policies), review and comment on the Peer Support Program's budgets, review activity offerings, and participate in dispute resolution activities for the program.
4. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and about the schedule of those activities and services, as well as other operational issues.
5. Regardless of organizational structure, the service must be directed and led by consumers themselves.
6. Peer Supports may include meals or other social activities for purpose of building peer relationships, but meals cannot be the central or core activity offered. The focus of the service must be skill maintenance and enhancement and building individual consumer's capacity to advocate for themselves and other consumers.
7. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The Program Leader must be able to call multidisciplinary team meetings regarding a participating individual's needs and desires, and a Peer Specialist providing services for and with a participating individual must be allowed to participate in multidisciplinary team meetings.

B. Staffing Requirements

1. The program must be under the clinical supervision of a Mental Health Professional preferably a consumer who is a Georgia-certified Peer Specialist, and preferably who is credentialed by the United States Psychiatric Rehabilitation Association (USPRA) as an Associate Psychosocial Rehabilitation Professional (APRP) or Registered Psychiatric Rehabilitation Professional (RPRP), or staff who can demonstrate activity toward attainment of certification as a Certified Psychiatric Rehabilitation Professional (CPRP).[1] All staff are encouraged to seek and obtain Georgia certification as a Peer Specialist and the CPRP credential.
2. The individual leading and managing the day-to-day operations of the program must be a Georgia-certified Peer Specialist, who is an APRP, RPRP, or CPRP or can demonstrate activity toward attainment of the CPRP credential.
3. The Program Leader must be employed by the sponsoring agency at least 0.5 FTE.

[1] NOTE: The United States Psychiatric Rehabilitation Association (usPRA) has changed its registration of professionals from APRP and RPRP to CPRP. This process will allow currently registered individuals until June 30, 2005 to complete the training and testing required for the new certification as a CPRP. After that date, the APRP and RPRP registration will end. Professionals seeking certification for the first time are required to follow the CPRP certification requirements.

4. The Program Leader and Georgia-certified Peer Specialists in the Peer Supports program may be shared with other programs as long as the Program Leader is present at least 75% of the hours the Peer Supports program is in operation, and as long as the Program Leader and the Georgia- certified Peer Specialists are available as required for supervision and clinical operations, and as long as they are not counted in consumer to staff ratios for 2 different programs operating at the same time.
5. Services must be provided and/or activities led by staff who are Georgia-certified Peer Specialists or other consumers under the supervision of a Georgia-certified Peer Specialist. A specific activity may be led by someone who is not a consumer but is an invited guest.
6. There must be at least 2 Georgia-certified Peer Specialists on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency.
7. The maximum face-to-face ratio cannot be more than 30 consumers to 1 certified Peer Specialist based on average daily attendance of consumers in the program.
8. The maximum face-to-face ratio cannot be more than 15 consumers to 1 direct service/program staff, based on the average daily attendance of consumers in the program.
9. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Consumer Council and psychosocial rehabilitation principles published by usPRA and must possess the skills and ability to assist other consumers in their own recovery processes.

C. Clinical Operations

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place offsite in natural community settings as appropriate for the Individualized Recovery Plan (IRP) developed by each consumer with assistance from the Program Staff.
2. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Peer Supports program is in operation except as noted above.
3. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the Peer Supports program must not be substantially different from space provided for other uses for similar numbers of individuals.
4. Staff of the Peer Supports Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits competitive and comparable to other staff based on experience and skill level.
5. Weekly progress notes must document individual progress relative to functioning and skills related to goals identified in the IRP.
6. Daily attendance of each consumer participating in the program must be documented for billing purposes.

7. When this service is used in conjunction with Psychosocial Rehabilitation and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review by the External Review Organization.
8. Consumers should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
9. Each consumer must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
10. A Peer Supports Program must offer a range of skill-building and recovery activities developed and led by consumers. These activities must include those that will most effectively support achievement of the consumer's rehabilitation and recovery goals.
11. The program must have a Peer Supports Organizational Plan addressing the following:
    - A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and:
      (a) View each individual as the director of his/her rehabilitation and recovery process
      (b) Promote the value of self-help, peer support, and personal empowerment to foster recovery
      (c) Promote information about mental illness and coping skills
      (d) Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy
      (e) Promote supported employment and education to foster self-determination and career advancement
      (f) Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed
      (g) Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice
      (h) Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process
    - A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule; if offered, meals must be described as an adjunctive peer relationship building activity rather than as a central activity.
    - A description of the staffing pattern, plans for staff who have or will have achieved Peer Specialist and CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
    - A description of how consumer staff within the agency are given opportunities to meet with or otherwise receive support from other consumers (including Georgia-certified Peer Specialists) both within and outside the agency.

- A description of how consumers are encouraged and supported to seek Georgia certification as a Peer Specialist through participation in training opportunities and peer or other counseling regarding anxiety following certification.
- A description of test-taking skills and strategies, assistance with study skills, information about training and testing opportunities, opportunities to hear from and interact with consumers who are already certified, additional opportunities for consumer staff to participate in clinical team meetings at the request of a consumer, and the procedure for the Program Leader to request a team meeting.
- A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians.
- A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes.
- A description of how consumers participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, about the schedule of those activities and services, and other operational issues.
- A description of the space, furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Supports services.
- A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity.
- A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP.
- A description of how consumer requests for discharge and change in services or service intensity are handled.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

Psychosocial Rehabilitation					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Day Treatment, Per Hour	H2012				

Definition of Service: A therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings and activities. Services include, but are not limited to:

1) Individual or group skill building activities that focus on the development of skills to be used by individuals in their living, learning, social and working environments,
2) Social, problem solving and coping skill development;
3) Illness and medication self-management;
4) Prevocational skills (for example: preparing for the workday; appropriate work attire and personal presentation including hygiene and use of personal effects such as makeup, jewelry, perfume/cologne etc as appropriate to the work environment; time management; prioritizing tasks; taking direction from supervisors; appropriate use of break times and sick/personal leave; importance of learning and following the policies/rules and procedures of the workplace; workplace safety; problem solving/conflict resolution in the workplace; communication and relationships with coworkers and supervisors; resume and job application development; on-task behavior and task completion skills such as avoiding distraction from work tasks, following a task through to completion, asking for help when needed, making sure deadlines are clarified and adhered to, etc; learning common work tasks or daily living tasks likely to be utilized in the workplace such as telephone skills, food preparation, organizing/filing, scheduling/participating in/leading meetings, computer skills etc) and
5) Recreational activities/leisure skills that improve self-esteem and recovery.

The programmatic goals of the service must be clearly articulated by the provider, utilizing a best/evidence based model for service delivery and support. These best/evidence based models may include: the Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based models and practices for psychosocial rehabilitation.

This service is offered in a group setting, though limited, non-routine one-to-one interventions are allowable within the service when more circumstantially appropriate. Group activities and interventions should be made directly relevant to the needs, desires and IRP goals of the individual participants (i.e. an additional activity/group should be made available as an alternative to a particular group for those individuals who do not need or wish to be in that group, as clinically appropriate).

This service may be provided as a step-down from intensive day treatment. Services must be provided in a clinic or other facility-based setting, and available at least 25 hours per week.

This service is offered for a maximum of 5 hours per day.

Target Population	Adults with Serious Mental Illness Adults with a -Co-Occurring Serious Mental Illness and Substance Related Disorder Adults with a Serious Mental Illness and CO-Occurring MR/DD
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition)
Unit Value	Unit=1 Hour
Reimbursement Rate	$11.13
Initial Authorization	180 days, 450 units
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	MH Day Services Provider 155 – Adult Mental Health
Admission Criteria	1. Individual must have primary behavioral health issues (including those with a co-occurring substance abuse disorder or MR/DD) and present a low or no risk of danger to themselves or others; and one or more of the following: 2. Individual lacks many functional and essential life skills such as daily living, social skills, vocational/academic skills and/or community/family integration; or 3. Individual needs frequent assistance to obtain and use community resources.
Continuing Stay Criteria	1. Primary behavioral health issues that continue to present a low or no imminent risk of danger to themselves or others (or is at risk of moderate to severe symptoms); and one or more of the following: 2. Individual improvement in skills in some but not all areas; or 3. If services are discontinued there would be an increase in symptoms and decrease in functioning; or 4. Increase needed in use of community supports with additional supports and skills training or length of time participating at this level is not significant enough to identify change in skill or community resource utilization.

Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual has acquired a significant number of needed skills; **or** 3. Individual has sufficient knowledge and use of community supports; **or** 4. Individual demonstrates ability to act on goals and is self sufficient or able to use peer supports for attainment of self sufficiency; **or** 5. Consumer/family need a different level of care; **or** 6. Consumer/family requests discharge.
Service Exclusions	1. Cannot be offered in conjunction with SA Day Services. 2. Service can be offered while enrolled in a Crisis Stabilization Program in a limited manner when documentation supports this combination as a specific need of the individual. Time and intensity of services in PSR must be at appropriate levels when PSR is provided in conjunction with other services. (This will trigger a review by the External Review Organization). This service cannot be offered in conjunction with Medicaid MR Waiver services.
Clinical Exclusions	1. Individuals who require one-to-one supervision for protection of self or others. 2. Individual has primary diagnosis of substance abuse, developmental disability, autism, or organic mental disorder without a co-occurring DSM IV mental disorder diagnosis. 3. Legal status requiring a locked facility.

Additional Service Criteria:

A. Required Components

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities should take place offsite in natural community settings as is appropriate to the participating consumer's Individualized Recovery Plan.
2. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the PSR program is in operation except as described above.
3. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the PSR program must not be substantially different from that provided for other uses for similar numbers of individuals.
4. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.

5. A PSR program must operate to assist individuals in attaining, maintaining, and utilizing the skills and resources needed to aid in their own rehabilitation and recovery.

B. Staffing Requirements

1. The program must be under the clinical supervision of a Mental Health Professional (MHP) who is credentialed as a Registered Psychosocial Rehabilitation Professional (RPRP), a Certified Psychosocial Rehabilitation Professional (CPRP)[2], or staff who can demonstrate activity toward attainment of certification.
2. Services must be provided and/or activities led by staff who are one of the following:
    - an MHP
    - a Substance Abuse Manager (SAM)
    - a Peer Specialist, CPRP, or Paraprofessional under the supervision of an MHP or SAM.
3. There must be an MHP present face-to-face at least 50% of all times the service is in operation up to 20 hours per week, regardless of the number of consumers participating.
4. The maximum face-to-face ratio cannot be more than 12 consumers to 1 direct service/program staff (including RPRPs and CPRPS) based on average daily attendance of consumers in the program.
5. At least one CPRP (or someone demonstrating activity toward attainment of certification) must be onsite face-to-face at all times (either the supervising MHP or other CPRP staff) while the program is in operation, regardless of the number of consumers participating. All staff are encouraged to seek and obtain the CPRP credential. All staff must have an understanding of recovery and psychosocial rehabilitation principles as published by USPRA and must possess the skills and ability to assist individuals in their own recovery processes.
6. Basic knowledge necessary for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
7. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
8. If the program does not employ someone who meets the criteria for a SAM, then the program must have documentation of access to an addictionologist and/or SAM for

[2] NOTE: The United States Psychosocial Rehabilitation Association (USPRA) has changed its registration of professionals from APRP and RPRP to CPRP. This process will allow currently registered individuals until June 30, 2005 to complete the training and testing required for the new certification as a CPRP. After that date, the APRP and RPRP registration will end. Professionals seeking certification for the first time are required to follow the CPRP certification requirements.

consultation on addiction-related disorders as co-occurring with the identified mental illness.

9. An MHP or SAM may be shared with other programs as long as these professionals are available as required for supervision and clinical operations and as long as they are not counted in consumer to staff ratios for two different programs operating at the same time.

C. Clinical Operations

1. Rehabilitation services facilitate the development of an individual's skills in the living, learning, social, and working environments, including the ability to make decisions regarding: self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual into the community.
2. Rehabilitation services are consumer driven and are founded on the principles and values of individual choice and active involvement of individuals in their rehabilitation. Through the provision of both formal and informal structures consumers are able to influence and shape service development.
3. Rehabilitation services must include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting rehabilitation goals; and skills teaching and development.
4. All individuals should participate in setting individualized goals for themselves and in assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
5. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
6. PSR programs must offer a range of skill-building and recovery activities from which individuals choose those that will most effectively support achievement of the individual's rehabilitation and recovery goals. These activities must be developed based on participating individual's input and stated interests. Some of these activities should be taught or led by consumers themselves as part of their recovery process.
7. A PSR program must be capable of serving individuals with co-occurring disorders of mental illness and substance abuse utilizing integrated methods and approaches that address both disorders at the same time (e.g. groups and occasional individual interventions utilizing approaches to co-occurring disorders such as motivational interviewing/building motivation to reduce or stop substance use, stage based interventions, refusal skill development, cognitive behavioral techniques, psychoeducational approaches, relapse prevention planning and techniques etc). For those individuals whose substance abuse and dependence makes it difficult to benefit from the PSR program, even with additional or modified methods and approaches, the PSR program must offer co-occurring enhanced services or make appropriate referrals to specialty programs specifically designed for such individuals.
8. The program must have a PSR Organizational Plan addressing the following:

a. Philosophical principles of the program must be actively incorporated into all services and activities including[3]:
    i. View each individual as the director of his/her rehabilitation process
    ii. Solicit and incorporate the preferences of the individuals served
    iii. Believe in the value of self-help and facilitate an empowerment process
    iv. Share information about mental illness and teach the skills to manage it
    v. Facilitate the development of recreational pursuits
    vi. Value the ability of each individual with a mental illness to seek and sustain employment and other meaningful activities in a natural community environment
    vii. Help each individual to choose, get, and keep a job (or other meaningful daily activity)
    viii. Foster healthy interdependence
    ix. Be able to facilitate the use of naturally occurring resources to replace the resources of the mental health system
b. Services and activities described must include attention to the following:
    i. Engagement with others and with community
    ii. Encouragement
    iii. Empowerment
    iv. Consumer Education and Training
    v. Family Member Education and Training
    vi. Assessment
    vii. Financial Counseling
    viii. Program Planning
    ix. Relationship Development
    x. Teaching
    xi. Monitoring
    xii. Enhancement of vocational readiness
    xiii. Coordination of Services
    xiv. Accommodations
    xv. Transportation
    xvi. Stabilization of Living Situation
    xvii. Managing Crises
    xviii. Social Life
    xix. Career Mobility
    xx. Job Loss
    xxi. Vocational Independence
c. A description of the particular rehabilitation models utilized, types of interventions practiced, and typical daily activities and schedule.
d. A description of the staffing pattern, plans for staff who will achieve CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.

[3] Adapted from Best Practices in Psychosocial Rehabilitation, edited by Hughes and Weinstein.

e. A description of how the program will assure that it is co-occurring capable and how it will adjust or make appropriate referrals for individuals needing a co-occurring enhanced PSR program.
f. A description of the hours of operation, the staff assigned, and the types of services and activities provided for consumers, families, parents, and/or guardians including how consumers are involved in decision-making about both individual and program-wide activities.
g. A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each IRP.
h. A description of services and activities offered for education and support of family members.
i. A description of how consumer requests for discharge and change in services or service intensity are handled and resolved.

D. Service Access

1. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Weekly progress notes must document the individual's progress relative to functioning and skills related to goals identified in his/her IRP.
2. Daily attendance of each consumer participating in the program must be documented showing the number of hours in attendance for billing purposes.
3. When this service is used in conjunction with Crisis Stabilization Programs, Peer Supports, and ACT (on a limited basis), documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts of PSR. Utilization of psychosocial rehabilitation in conjunction with these services is subject to review by the External Review Organization.

Rehabilitative Supports for Individuals in Residential Alternatives Levels 1 & 2

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing, Per Diem	H0043	U1			
Supported Housing, Per Diem	H0043	U2			

Definition of Service: Residential Rehabilitative Supports are comprehensive rehabilitative services to aid adults in developing daily living skills, interpersonal skills, and behavior management skills; and to enable adults to manage symptoms and regain lost functioning due to mental illness, substance abuse, and/or co-occurring disorders

Services are delivered to individuals according to their specific needs. Individual and group activities and programming must consist of services to restore and develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; regain or maintain competitive employment; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.

Rehabilitative services must be provided in a licensed/certified residential setting with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. All facilities providing residential rehabilitative supports must be staffed 24 hours a day, 7 days a week.

Target Population	Adults with Serious Mental Illness, Adults with Substance Abuse Issues, Adults with Co-Occurring Substance Abuse and Mental Illness Adults with Co-Occurring Mental Illnesses and MR/DD. Adults with Co-Occurring Substance Related Disorders and MR/DD.	
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.	
Practice Guidelines	Available to those with LOCUS scores: 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential	
Unit Value	Unit=1 day	
Reimbursement Rate	H0043U1	$31.34
	H0043U2	$38.58
Initial Authorization	180 days	
Re-Authorization	180 days	
Authorization Period	180 days	

UAS: **Budget and Expense Categories**	Adult Residential Services Provider Residential Alternatives I: 142 – Adult Mental Health 742 – Adult Addictive Diseases Residential Alternatives II: 143 – Adult Mental Health 743 – Adult Addictive Diseases
Admission Criteria	1. Individual must have symptoms of a mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition
Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Program. Residential Rehabilitative Supports 1 and 2 cannot be billed simultaneously.
Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.

2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to youth with SED and/or substance abuse diagnosis. If the agency does not have a license/letter from ORS related to operations, there must be enough administrative documentation to support the non-applicability of ORS license.
3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week.
4. Level I Residential Rehabilitation Services must provide 4 hours per week of structured programming and/or services.
5. Level II Residential Rehabilitation Services must provide 6 hours per week of structured programming and/or services.

B. Staffing Requirements

1. A Mental Health Professional or SAM, or a paraprofessional under the supervision of a Mental Health Professional or SAM must provide all Residential Rehabilitation Services.
2. If applicable, facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Office of Regulatory Services.
3. A Mental Health Professional or SAM must supervise all Residential Support Services.
4. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include address all ORS/accreditation/certification requirements
5. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

***C.* Clinical Operations**

1. The organization must have a written description of the Residential Rehabilitation services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and expected outcomes.
2. Residential Rehabilitation Services assist individuals in developing daily living skills that enable them to manage the symptoms of and regain functioning lost due to their psychiatric or addictive disorder. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward restoring and developing skills in functional areas that interfere with the individual's ability to live in the community, live independently, regain or maintain competitive employment, develop or maintain social relationships, or independently participate in social, interpersonal, or community activities.
3. Residential Rehabilitation Services must include symptom management or supportive counseling; medication education, training and support; support, supervision, and problem solving skill development; development of community

living skills that serve to promote independent utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate appropriate interpersonal behavior.

D. Service Access

E. Additional Medicaid Requirements

1. This is a Medicaid-billable service and is subject to all Medicaid policies, procedures, and rules.
2. Any facility billing Medicaid for this service may not exceed 16 beds.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. The organization must develop and maintain sufficient written documentation to support the Residential Rehabilitation Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Rehabilitation Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Residential Rehabilitation Services may only be provided in facilities that have no more than 16 beds.
2. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
3. Each residential facility must comply with all relevant fire safety codes.
4. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
5. The organization must comply with the American with Disabilities Act.

6. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted.
7. Evacuation routes must be clearly marked by exit signs.
8. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Residential Substance Detoxification					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Alcohol and/or Other Drug Services; Sub-acute Detoxification (Residential Addiction Program Outpatient)	H0012				

Definition of Service: Residential Substance Detoxification is an organized and voluntary service that may be delivered by appropriately trained staff who provide 24-hour per day, 7 day per week supervision, observation and support for individuals during detoxification. Residential detoxification is characterized by its emphasis on medical monitoring and/or on peer/social support, and should reflect a range of residential detoxification service intensities from ASAM (American Society of Addiction Medication) Level III.2D to III.7D. These levels provide care for individuals whose intoxication/withdrawal signs and symptoms may only require 24-hour supervision, observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of service.

Target Population	Adults and Older Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	Unit=1 day (per diem)
Reimbursement Rate	$85.00
Initial Authorization	30 days
Re-Authorization	
Authorization Period	30 days
UAS: **Budget and Expense Categories**	Addictive Diseases Detox Services Provider 765 – Adult Addictive Diseases 865 – C&A Addictive Diseases

Admission Criteria	1. Individual has a Substance Induced Disorder as defined in the latest version of the DSM (ASAM PPC-2, Dimension-1 and is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as manageable at this level of service; **and** 2. There is strong likelihood that the individual will not complete detoxification at another level of service and enter into continued treatment or self-help recovery **as evidenced by one of the following**: a. individual requires medication and has recent history of detox at a less intensive service level, marked by past and current inability to complete detox and enter continuing addiction treatment; individual continues to lack skills or supports to complete detox, **or** b. individual has a recent history of detox at less intensive levels of service marked by inability to complete detox or enter into continuing addiction treatment and continues to have insufficient skills to complete detox, **or** c. individual has co-morbid physical or emotional/behavioral condition that is manageable in a Level III.7-D setting but which increases the clinical severity of the withdrawal and complicates detoxification.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can be managed in a less intensive service.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level IV-D detoxification service is indicated.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Residential Detoxification is not to be billed as Medication Administration.)
Clinical Exclusions	Concomitant medical condition and/or other behavioral health issues warrant inpatient treatment or Crisis Stabilization Program admission.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate a detoxification regimen.
3. Medication administration may be initiated only upon the order of a physician.
4. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

1. Services must be provided by a combination of nursing, other licensed medical staff, and other residential support under supervision of a physician.
2. In programs that are designed to target older adolescents, staffing patterns must reflect staff expertise in the delivery of services to that age population. In addition, higher staffing ratios would be expected in these programs related to supervision.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients, this service may be billed as Rehabilitative Supports for Individuals in Residential Alternatives – Level 2 if all other applicable requirements have been met. Please see the Rehabilitative Supports for Individuals in Residential Alternatives – Level 2 service definition for service requirements; OR
2. For Medicaid recipients, this service may be billed to Medicaid as "Crisis Residential" if the individual is receiving this service as a part of a Crisis Stabilization Program (see related code for requirements).

F. Reporting Requirements

1. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.

Respite					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Respite Care Services, Not in the Home, Per Diem	H0045				
Unskilled Respite Care, Not Hospice, Per Diem	S5151				

Definition of Service: Respite services are brief periods of support or relief from current debilitating situations for individuals with mental illnesses and/or substance related disorders. Respite is provided: (1) when an individual is experiencing a psychiatric, substance related or behavioral crisis and needs structured, short-term support; (2) consumer-identified natural supports are unable to provide necessary illness-management support and thus the individual is in need of additional support or relief; or (3) when the individual and his/her identified natural supports experience the need for therapeutic relief from the stresses of their mutual cohabitation. Respite may be provided in-home (i.e. provider delivers service in individual's home) or out-of-home (individual receives service outside of their home), and may include day activities as well as overnight activities/accommodations as appropriate to the situation.

Target Population	Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential
Unit Value	Unit=1 day
Reimbursement Rate	$56.00
Initial Authorization	While the actual respite should be very short-term in nature, this service can be authorized as part of a 180 day Recovery/Resiliency plan. A maximum of 30 days may be provided to a single individual in a single authorization period.
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Consumer/Family Support Services Provider 136 – Adult Mental Health 736 – Adult Addictive Diseases

Admission Criteria	1. Individual meets target population as identified above; **and** 2. Individual has a need for short-term support which could delay or prevent the need for out-of-home placement or higher levels of service intensity (such as acute hospitalization); **and one or more of the following:** 3. Individual has a circumstance which destabilizes his/her current living arrangement and the provision of this service would provide short-term relief and support of the individual; **or** 4. The consumer-identified natural supports network has an immediate need for support and relief from its role of supporting the individual in his/her behavioral health crises 5. The consumer-identified natural supports network has an immediate need to participate in an emergency event during which lack of support may cause the individual a setback in his/her Recovery plan.
Continuing Stay Criteria	1. Individual continues to meet admission criteria as defined above; **and** 2. Individual has developed a Recovery goal to develop natural supports that promote the self/family-management of these needs.
Discharge Criteria	1. Individual requests discharge; or 2. Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	Traditional 24/7 Residential Supports (Service may be provided in addition to Therapeutic Foster Care on a limited basis to preserve placement).
Clinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services).

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

C. Clinical Operations

D. Service Access

1. A maximum of 30 days may be provided to a single individual in a single authorization period.

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid-billable service.

F. Reporting Requirements

1. All other applicable MICP and DMHDDAD reporting requirements must be adhered to.

Room & Board					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**

Definition of Service: Effective October 1, 2006, this is a rental subsidy that must be justified by a personal consumer budget.

Target Population	Non-SSI Recipients who are Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	Unit=1 day
Reimbursement Rate	$13.15/day maximum that DMHDDAD will pay
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Residential Services Provider 148– C&A Mental Health 748 – C&A Addictive Diseases
Admission Criteria	1. Individual meets target population as identified above; **and** 2. Based upon a personal budget, individual has a need for financial support for a living arrangement.
Continuing Stay Criteria	1. Individual continues to meet admission criteria as defined above; **and** 2. Individual has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs.
Discharge Criteria	1. Individual requests discharge; or 2. Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	Crisis Residential Services

Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury.

Substance Abuse Day Treatment					
HIPAA Transaction Code	**Code**	**Mod1**	**Mod2**	**Mod3**	**Mod4**
Behavioral Health Day Treatment, Per Hour	H2012	HB	HF		

Definition of Service: A time limited, multi-faceted approach treatment service for persons who require structure and support to achieve and sustain recovery from substance related disorders. These services are available during the day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school and to be a part of their family life. The following types of services may be included:

1) Didactic presentations/ psychoeducational approaches;
2) Individual counseling;
3) Group counseling;
4) Family counseling and family didactic/psychoeducational approaches (as appropriate); and
5) Regular urine drug screenings.

This service should be scheduled and available at least 5 hours per day, 4 days per week, with no more than two consecutive days without service availability for high need individuals (ASAM Level II.5). There should be at least 3 hours of scheduled services available per day, 3 days per week with no more than two consecutive days without service availability for lower need individuals (ASAM Level II.1). The maximum number of hours that can be billed within one day for any one individual is 5 hours. An Adult Substance Abuse Day Services Program may have variable lengths of stay. It is recommended that individuals attend at a frequency appropriate to their level of need and that each individual's frequency of attendance be reduced as recovery becomes established and the individual becomes able to resume more and more usual life roles and obligations.

Strategies for recovery and relapse prevention should include community and social support systems in the planned interventions. Services are provided according to individual needs and goals as articulated in the Individualized Recovery Plan. The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence based practices for service delivery and support that are based on the population(s) and issues to be addressed. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, co-occurring disorder approaches, relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adults with Substance Related Disorders, including those with a Co-occurring Mental Illness or Developmental Disability.
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.

Practice Guidelines	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Unit Value	Unit=1 hour
Reimbursement Rate	$13.50
Initial Authorization	450 units
Re-Authorization	450 units
Authorization Period	180 days
UAS: **Budget and Expense Categories**	<u>Addictive Disease Day Services Provider</u> 756 – Adult Addictive Diseases
Admission Criteria	1. A DSM IV diagnosis of Substance Abuse or Dependence or substance- related disorder with a co-occurring DSM IV diagnosis of mental illness or DD; **and one or more of the following:** 2. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational functioning; **or** 3. The individual's substance abuse history after previous treatment indicates that provision of outpatient services alone is not likely to result in the individual's ability to maintain sobriety; **or** 4. The individual is able to function in a community environment even with impairments in social, medical, family, or work functioning; **or** 5. The individual is sufficiently motivated to participate in treatment; **or** 6. There is a reasonable expectation that the individual can improve demonstrably within 3-6 months[2]; **or** 7. The individual is assessed as needing ASAM Level II or III.1; **or** 8. The individual has no significant cognitive and/or intellectual impairments that will prevent participation in and benefit from the services offered and has sufficient cognitive capacity to participate in and benefit from the services offered; **or** 9. The individual is not actively suicidal or homicidal, and the individual's crisis, Intensive Day Treatment, and/or inpatient needs (if any) have been met prior to participation in the program.
Continuing Stay Criteria	1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a

[2] Program serving TANF eligible clients must seek review every 3 months in accordance with TANF policy.

	commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
Discharge Criteria	1. An adequate continuing care or discharge plan is established and linkages are in place; **and one or more of the following:** 2. Goals of the Individualized Recovery Plan (IRP) have been substantially met; **or** 3. The individual requests discharge and is not in imminent danger of harm to self or others; **or** 4. Transfer to another level of service is warranted by change in the individual's condition or nonparticipation; **or** 5. The individual refuses to submit to random drug screens; **or** 6. The individual requires services not available at this level.
Service Exclusions	Services cannot be offered with Intensive Day Treatment or Psychosocial Rehabilitation. When offered with ACT or Crisis Residential Services, documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the External Review Organization.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Substance Abuse Day Services emphasizes reduction in use and abuse of substances and/or continued abstinence; the negative consequences of substance abuse; development of social support network and necessary lifestyle changes; educational skills; vocational skills leading to work activity by reducing substance abuse as a barrier to employment; social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.
3. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program may also utilize group and/or individual counseling and/or therapy.
4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.

6. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning.
7. The program is provided over a period of several weeks or months and often follows detoxification or residential services.
8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's IRP. Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Day Services Program may not be counted toward the SA Day Services billable hours for any individual, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
9. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Substance Abuse Day Services is in operation.
10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Day Services program must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a Substance Abuse Manager (SAM) who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
    - a SAM or
    - a Substance Abuse Professional (SAP) or
    - a Paraprofessional under the supervision of an MHP or SAM
3. Basic knowledge necessary for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in the Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Individuals with Co-Occurring Disorders.
4. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
5. There must be a SAM or a SAP on-site at all times the service is in operation, regardless of the number of individuals participating.

6. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct service/program staff based on average daily attendance of individuals in the program.
7. The maximum face-to-face ratio cannot be more than 20 individuals to 1 SAP based on average daily attendance of individuals in the program.
8. A physician and a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer physician and/or nursing services. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
9. A SAM or SAP may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service options will begin at the onset of this service delivery. Documentation must demonstrate this planning.
2. Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
3. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in use/abuse and maintenance of recovery.
4. Substance Abuse Day Services programs must offer a range of skill-building and recovery activities within the program, including but not limited to:
    - Psycho-educational activities focusing on the disease of addiction, relapse prevention, and the health consequences of addiction
    - Therapeutic group treatment and counseling
    - Individual support for recovery
    - Individualized treatment, service, and recovery planning
    - Assessment and reassessment
    - Drug screening/toxicology examinations
    - Leisure and social skill-building activities without the use of substances
    - Family education and engagement
    - Vocational readiness and support
    - Linkage to health care
    - Linkage to natural supports and self-help opportunities
    - Service coordination unless provided through another service provider
5. In addition to these required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with

another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Day Services:

- Community Support – Individual – for housing, legal and other issues
- Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
- Physician assessment and care
- Psychological testing
- Nursing assessment and health screening.

6. The program must have a Substance Abuse Day Services Organizational Plan addressing the following:

    - The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
    - The schedule of activities and hours of operations.
    - Staffing patterns for the program.
    - How the activities listed in number 11 above will be offered and/or made available to those individuals who need them, including how that need will be determined.
    - How assessments will be conducted.
    - How staff will be trained in the administration of addiction services and technologies.
    - How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
    - How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
    - How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
    - How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
    - How the requirements in these service guidelines will be met.

D. Service Access

1. The program is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those

individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those needing 20 hours or more of structured services per week (ASAM Level II.5 or III.1) in order to begin recovery and learn skills for recovery maintenance. The program may offer services a minimum of only 3 hours per day for only 3 days per week with no more than 2 consecutive days between offered services if only individuals at ASAM Level II.1 are served.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MICP, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Every admission and assessment must be documented.
2. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness.
3. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes.
4. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance Abuse Day Services in conjunction with these services is subject to review by the External Review Organization.

Supported Employment

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Employment	H2023				

Definition of Service: In line with current best practice, this service emphasizes that a rapid job search and placement approach be prioritized above traditional prevocational training or traditional vocational rehabilitation. Job development, placement and training are for people who, due to the severity of their disabilities, need support to locate, choose, obtain, learn and maintain a job. Services include supports to choose and obtain paid employment in competitive wage, individual-based community jobs, as well as brief training support to learn the specific job skills/tasks necessary to perform and retain a particular job. Services are provided to any individual interested in obtaining employment, regardless of the degree of disability, and with particular attention and consideration to the individual's interests, strengths, needs, capabilities, priorities, concerns, previous work experiences and informed choice **(i.e. job placement should be individualized).**

Once a job is obtained, brief on-the-job training and support is available through this service to assist individuals in learning the job-specific skills/tasks necessary to successfully performing the new job.

It is expected that service staff will maintain regular, meaningful collaboration with the individual's mental health/substance abuse treatment team.

Services may be provided in a variety of settings and must meet the following specific service criteria:

1) Employment is paid;
2) Employment provides opportunities to interact with people who do not have disabilities;
3) Training includes brief teaching/modeling of the specific skills/tasks necessary to perform the job; and
4) Regular, meaningful collaboration with the mental health/substance abuse treatment team is maintained.

Moreover, the service should maintain a focus on the individual's long-term career goals if a career is important to the individual, and attempt to place the individual in a job accordingly, rather than simply placing the individual in the easiest, lowest requirement job available. Jobs may be full or part time, and frequent opportunities for individuals to interact with non-disabled co-workers during the performance of their jobs or during breaks, working hour meals or travel to and from work is an important benefit. More than one individual consumer with a disability could work for the same employer and still be considered to receive this service, as long as consumers are not grouped within the work site. Wages must be paid in compliance with all applicable Department of Labor requirements.

The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services. Practitioners providing this service

are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adults and Older Adolescents with a: Mental Illness Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Illness, Co-Occurring Mental Illness and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP Part I and a MICP Part II.
Practice Guidelines	Available to those with LOCUS scores: 3: High Intensity Community-Based Services
Unit Value	Unit=1 month
Reimbursement Rate	$310
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
UAS: **Budget and Expense Categories**	Employment Services Provider 139 – Adult Mental Health 239 – C&A Mental Health (for older adolescents) 739 – Adult Addictive Diseases 839 – C&A Addictive Diseases (for older adolescents)
Admission Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; **and** 2. Individuals for whom behavioral health issues have caused unemployment or underemployment.
Continuing Stay Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; **and** 2. Individuals for whom behavioral health issues have caused unemployment or underemployment; **and** 3. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan for employment, but employment goals have not yet been achieved.
Discharge Criteria	1. Goals of the Individualized Recovery Plan related to employment have been substantially met; or 2. Individual requests a discharge from this support.

Service Exclusions	
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services.
2. Wages must be paid in compliance with all applicable Department of Labor requirements.

B. Staffing Requirements

1. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

C. Clinical Operations

1. Individuals should be encouraged to be as involved and self-directed in the job location and placement process as possible (e.g. the individual should call a potential employer to inquire about a job rather than staff calling when possible (which may entail coaching the individual), and the individual should be offered assistance—though not advice--from staff in making the personal decision about whether or not to disclose his or her disability to a potential employer).

D. Service Access

E. Additional Medicaid Requirements

1. Not Applicable. Not a Medicaid-billable service.

F. Reporting Requirements

1. All applicable MICP and other DMHDDAD reporting requirements must be adhered to.
2. A monthly-standardized report may be required by the DMHDDAD to monitor outcomes.

GEORGIA DMHMRSA – BEST PRACTICE SUGGESTIONS

PRINCIPLES AND STAFF CAPABILITIES FOR DAY SERVICES FOR ADULTS WITH CO-OCCURRING DISORDERS – April 17, 2002

Principles

1. Services for persons with co-occurring disorders should be integrated, rather than sequential. That is, they should be structured to deal with both disorders at once rather than requiring one disorder or one set of symptoms to be dealt with before services for the other can begin.
2. Psychosocial Rehabilitation (PSR) programs and Substance Abuse (SA) Day Services programs will be initially encouraged and eventually required to work toward becoming "co-occurring capable," that is, able to deal flexibly with the issues of persons with co-occurring disorders.
3. "Co-occurring enhanced" services are time limited and go beyond co-occurring capable services and programs. They are characterized by the following:
    - Additional or special assessments requiring additional training or competencies, perhaps utilizing additional or specialized assessment tools;
    - Special training, experience, licensure, certification, or other qualifications of staff beyond basic recognition and general capabilities of addressing the needs of persons with co-occurring disorders within a larger program (see recommended staff capabilities below);
    - Availability of addictionologist and/or SAM consultation;
    - Availability of psychiatric consultation and/or medication management;
    - Availability of crisis services if needed, either directly or through an interagency agreement with a mobile crisis service;
    - Additional staff to client ratio beyond the minimum requirements for a limited period of time, in order to deal effectively with individuals needing more intense or more frequent services than those offered in a co-occurring capable day services program; and
    - Additional programming intensity or specialized approaches or activities requiring significant adjustments to the usual day services activities to assure adequate dosing, frequency, and integration of services for individuals with co-occurring disorders.
4. Programs that provide PSR or SA Day Services will be required to either provide or arrange for co-occurring enhanced integrated services for adults with co-occurring disorders until those individuals can move back into regular co-occurring capable day services. Adults with co-occurring disorders should not be expected to simply adapt to usual or routine PSR or SA Day Services activities.
5. Co-occurring enhanced day services may be provided within a larger SA Day Services or PSR program, may be a separate day services program within a larger agency, or may be a stand-alone service provider.
6. An adult with serious and persistent mental illness and a co-occurring substance abuse disorder should be served in a co-occurring capable or co-occurring enhanced PSR program. Adults with substance abuse or dependence who also have a co-occurring mental health needs that do not rise to the level of serious and persistent mental illness should be served in a co-occurring capable or co-occurring enhanced SA Day Services.

7. An adult with serious and persistent mental illness whose symptoms are stable enough so that Intensive Day Treatment is not indicated; whose cognitive functioning is high enough to participate in and benefit from a co-occurring capable SA Day Services program without distraction; whose coping skills and abilities are sufficiently intact to allow attention to his/her substance abuse; and who can understand the emotional concerns related to the negative consequences and effects of addiction should be allowed to choose service in a SA Day Services program. An adult with serious and persistent mental illness may not be refused service in an SA Day Services program simply because he/she is seriously and persistently mentally ill. Likewise, a seriously and persistently mentally ill adult may not be refused service in a PSR program simply because he/she is abusing or dependent on alcohol or other drugs.
8. Adults with serious and persistent mental illness whose symptoms, cognition, functioning, or coping skills are sufficiently impaired to prevent participation or benefit from a co-occurring capable day services program but who meet the admission criteria for either PSR or SA Day Services, must be served by a co-occurring enhanced PSR or SA Day Services program.
9. The service guidelines for PSR Services and for SA Day Services will include the same requirements about cross training and capabilities of staff to recognize and treat adults with co-occurring disorders.
10. DMHMRSA will work to ensure that there is no financial disincentive to serving individuals with co-occurring disorders in any particular day services program.
12. Basic knowledge necessary for all staff serving persons with mental illness or substance abuse in "co-occurring capable" day services must include the content areas below. For programs that are "co-occurring enhanced," this knowledge must go beyond basic understanding and must demonstrate actual staff competencies in using that knowledge to serve adults with co-occurring disorders.
13. PSR and SA Day Services Program Managers and staff are encouraged to become familiar with ASAM's Patient Placement Criteria – 2R and current evidence-based practices literature about serving adults with co-occurring disorders.

GEORGIA DMHMRSA – BEST PRACTICES SUGGESTIONS

Staff Knowledge and Capabilities
About
Serving Persons with Co-Occurring Disorders

Necessary Capabilities For Substance Abuse Staff	Necessary Capabilities For Mental Health Staff
• knowledge of mental illness diagnoses, symptoms, and cognitive impairments where applicable; • medications used to treat various types of mental illness and their effects, including undesired medication side effects and the effects of discontinuing these medications; • assessment of mental illness; • likely coping strategies of individuals with mental illness, including use and abuse of substances, • concept of role of family members and psychoeducational approaches for working collaboratively with them; • motivational counseling for clients who are not ready to take full responsibility for self-management and recovery from substance abuse; • behavioral counseling for those who are actively working on recovery; • denial about mental illness or its symptoms, while respecting and encouraging individual choice and responsibility; • individual strategies for preventing symptom exacerbation; and • difference between recovery and engagement concepts in mental health and in substance abuse.	• knowledge of substances of abuse and how they affect mental illnesses; • symptoms of withdrawal from various types of substances of abuse; • complications of interactions between psychotropic medications and substances of abuse, especially in detoxification and withdrawal processes; • assessment of substance abuse; • special considerations in assessing substance abuse in adults who have symptoms associated with a mental illness or who are taking or are candidates for taking prescribed medications for a diagnosed mental illness; • motivational counseling to use with clients who appear to be unmotivated for substance abuse treatment; • behavioral substance abuse counseling for those who are motivated to work toward abstinence; • denial and its role in addiction; • methods for overcoming denial while respecting and encouraging individual choice and responsibility; • relapse prevention strategies for persons with addictions; and • difference between recovery and engagement concepts in substance abuse and in mental health.